



*the Journal*  
**ICHIGAN**

STATE MEDICAL SOCIETY

FEBRUARY 1961 • VOLUME 60 • NUMBER 2



In Tribute to  
Wilfrid Haughey, M.D.,  
Editor, MSMS Journal



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Volume 60

Number 2

February, 1961

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Published monthly except two issues to be published in January and August, by the Michigan State Medical Society as its official journal at 2642 University Avenue, Saint Paul 14, Minnesota.

Second class postage paid at Saint Paul, Minnesota.

Yearly subscription rate, \$6.00; single copies, 60 cents. Additional postage: Canada, \$1.00 per year; Pan-American Union, \$2.50 per year; Foreign, \$2.50 per year.

Office of Publication  
2642 University Avenue  
Saint Paul 14, Minnesota

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PRINTED IN U.S.A.



## THE COVER

The fine portrait of Wilfrid Haughey, M.D., Editor of THE JOURNAL MSMS, was made by John S. Coppin, of Detroit, and was made available by the Michigan Medical Service. The cover art and this tribute to Dr. Haughey will be a surprise to him!

February, 1961

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## President's Page

THANKS, DR. HAUGHEY!



This month I'd like to add my plaudits to all Medical Writers and especially to MSMS Editor Wilfrid Haughey, M.D.

Some months ago, when the idea of dedicating this February JOURNAL was developed, The Council and its Publication Committee were enthusiastic about devoting this number to medical writers. Then, when the medical writers themselves began to work out the details, they quickly seized the opportunity to recognize the outstanding service performed by Editor Haughey.

And lest anyone be accused of immodesty, let me assure you that the cover design and the excellent guest editorial by J. P. Gray, M.D., were kept a deep, dark secret from Doctor Haughey.

Medical writers with their unique ability to communicate through the written word perform an extremely valuable service for the medical profession.

Gentlemen, we salute you all!

But, if I may, I would like to single out Doctor Haughey, the Dean of Michigan Medical Writers, for special praise. Doctor Haughey's talents and editing ability have been recognized many times over the years. Yet, to me, it seems that not enough has been said about the devotion of this man to his avocation. Each month, Doctor Haughey is confronted with the huge task of selecting scientific material, writing timely and informative editorials, and coordinating the entire Journal from thought to print.

The hours of proof-reading, correcting, and making countless decisions are mainly a thankless task, but there are some rewards. First, the respect and admiration of MSMS for a job well done brings satisfaction; and certainly, all of us take pride in the fact that the MSMS JOURNAL was one of three state medical journals singled out for honors by the 1959 American Medical Association Conference of Journal Editors.

The improvements in typography, layout and design—the "new look" of JMSMS—is a measure of the Editor who is not content with status quo. I am sure the future holds even greater improvements in all departments, so that Michigan doctors will have the finest editorial voice among state medical publications—thanks to Medical Writer Haughey!

*Kenneth H. Husea*

# Resolution Institutes MSMS Presidents Program

STATE SOCIETY 157

*Members Urged to Read House of Delegates  
Resolution, Printed Here in Full*

MSMS members will be invited in the coming months to participate in the new five-year Presidents Program, which was instituted by the 1960 MSMS House of Delegates. The five-year program will lead up to the Centennial Celebration by the State Medical Society in 1965.

At the House of Delegates, Kenneth H. Johnson, M.D., MSMS President, pointed out that the plan offers Michigan doctors of medicine an opportunity to present a united front at a time when social changes are challenging the profession.

Resolution No. 25, which institutes the Program, follows in full:

WHEREAS, the challenge of today to the medical profession is to revitalize the unique power of the individual doctor to serve the whole person in sickness and in health, and

WHEREAS, to gain maximum benefit from the monumental gains of modern medical research it is necessary that the research findings be applied at the earliest opportunity to the maximum number of persons who could benefit by these new drugs, treatments, techniques or concepts of medical and health care, and

WHEREAS, the medical profession wishes to join with those segments of the public which are primarily concerned with health (as well as with all persons or groups who can make effective contributions to the general public health) as partners in a single, well-defined health program, and

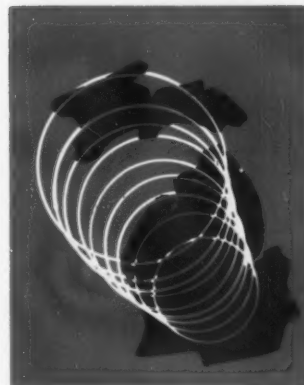
WHEREAS, the Michigan State Medical Society, which has pointed with pride over the past 95 years to separate, individual "firsts" in medically-oriented activity, can now evidence the same willingness to serve the public interest by offering its leadership in a single, well-conceived and executed, integrated program, therefore be it

RESOLVED: That a five-year project be inaugurated by the Michigan State Medical Society specifically designed to utilize to the fullest extent:

- A. The capabilities and knowledge of its individual members as leaders,
- B. The facilities of its new headquarters as a "Campaign Control Center," and
- C. Its staff and resources as communicating and coordinating services, toward the end of expediting plans which will hope to
  1. result in an increase of 5 years in the general life expectancy of the people of Michigan, said increase to be attempted over the period of time beginning in September 1960 and concluding in September 1965 (the 100th anniversary of the Michigan State Medical Society), and
  2. increase the potential productivity and usefulness of additional years of life; and be it further

RESOLVED: That to accomplish this goal The Council of the Michigan State Medical Society be empowered and urged to:

- A. Seek the advice, aid and assistance of all members of the Michigan State Medical Society, as well as all related scientists, and the enthusiastic support of its county and district medical societies,
- B. Support all reasonable efforts to place the latest developments of research into the armamentarium of the doctors of medicine of Michigan at the earliest possible date,
- C. Request the assistance of, and coordinate its work and recommendations with, those qualified voluntary and governmental agencies to gain a maximum amount of progress toward the goal with a minimum of duplication of effort; and be it further



RESOLVED: That this effort be carried out at the top level of organizational work and to that end this project be promoted by each succeeding President of the Michigan State Medical Society during the next five years who will work in conjunction with the titular heads of all other pertinent organizations; and be it further

RESOLVED: That this project be known as the Presidents Program.

## Mrs. Urmston Dies

Mrs. Louise T. Urmston, widow of the late Paul R. Urmston, M.D., died at her home at Bay City in early December. Her husband, Doctor Urmston, who died August 24, 1960, was president of the Michigan State Medical Society in 1940.

Mrs. Urmston had spent most of her life in Bay City where Doctor Urmston practiced otolaryngology for many years.

## MCI to Stress Practical Applications

Speakers at the 1961 Michigan Clinical Institute will give special emphasis to the practical application of new medical advances, reports General Chairman Milton A. Darling, M.D., of Detroit.

The total program, he said, was planned to help the practicing physician in his daily work.

The refresher course will begin Wednesday morning and end Friday noon, March 8-10, at the Sheraton-Cadillac Hotel, Detroit.

The opening session on Wednesday will feature scientific papers on surgery. Wednesday afternoon will be devoted to trauma. "The Use and Abuse of Hypnosis" will be discussed by a panel of eminent men on Wednesday evening. Thursday morning will feature speakers on heart and rheumatic fever and the program Thursday afternoon will stress internal medicine and cancer. There will be an evening meeting on Thursday, emphasizing in particular the care of older people in nursing homes and homes for the elderly. Friday morning will report new advances in obstetrics and gynecology.

**SOMETHING NEW—EIGHT DISCUSSION GROUPS.** These instructional courses on topics of practical value must be limited in attendance to thirty M.D.s each, due to the facilities available in the hotel.

For your convenience in indicating which Discussion Group you wish to attend, reservation blank follows. Admission tickets will be mailed to those registering, on a "first come, first served" basis.

### Reservation Blank

#### "DISCUSSION GROUPS" 1961 MICHIGAN CLINICAL INSTITUTE

Please select the one "Discussion Group" in which you would like to participate each day:

WEDNESDAY, MARCH 8, 1961, 8:00-9:00 a.m.:

1. "Chemotherapy in Malignant Disease"  
☐ LEADER: George S. Fisher, M.D., Detroit  
PANELISTS: Michael J. Brennan, M.D., Detroit  
Alvin Watne, M.D., Buffalo, New York
2. "X-Ray Diagnosis in Surgical Practice"  
☐ LEADER: Steven J. Figiel, M.D., Detroit  
PANELISTS: Fred J. Hodges, M.D., Ann Arbor  
Elmer F. Wahby, M.D., Grand Rapids
3. "Unusual Fractures"  
☐ LEADER: Herbert D. Pedersen, M.D., Dearborn  
PANELISTS: Robert W. Bailey, M.D., Ann Arbor  
J. Otto Lottes, M.D., St. Louis, Missouri

THURSDAY, MARCH 9, 1961, 8:00-9:00 a.m.:

1. "Respiratory Antigens: Preparation, Demonstration, and Administration"  
☐ LEADER: Fred M. Davenport, M.D., Ann Arbor  
PANELISTS: Peter P. Barlow, M.D., Ann Arbor  
Sidney Friedlaender, M.D., Detroit
2. "Anemia"  
☐ LEADER: Raymond W. Monto, M.D., Detroit  
PANELISTS: Freeman M. Wilner, M.D., Detroit  
Chris J. D. Zarafonitis, M.D., Philadelphia, Pennsylvania
3. "Selection of Patients for Cardiac Surgery"  
☐ LEADER: Prescott Jordan, M.D., Detroit  
PANELISTS: Charles P. Bailey, M.D., New York City  
Franklin D. Johnston, M.D., Ann Arbor  
Richard R. Rasmussen, M.D., Grand Rapids

FRIDAY, MARCH 10, 1961, 8:00-9:00 a.m.:

1. "Newer Drugs in the Treatment of Pregnancy Toxemia"  
☐ LEADER: Charles S. Stevenson, M.D., Detroit  
PANELISTS: David N. Danforth, M.D., Evanston, Illinois  
Arthur G. Seski, M.D., Detroit
2. "Serious Complications of Pregnancy"  
☐ LEADER: Francis A. Jones, M.D., Lansing  
PANELISTS: Charles A. Behney, M.D., Lansing  
Laurel S. Eno, M.D., Detroit  
Edward C. Mann, M.D., New York City

Note: Members may submit in writing three weeks before the MCI, through Chairman of the Program Committee, John W. Sigler, M.D., c/o P.O. Box 539, Lansing 3, Michigan, questions concerning any phase of the subjects listed above. Moderators and Panelists will answer those questions which they feel are applicable to the subject under discussion, and will answer as many other questions as time permits.

Signed: .....

Address: .....

City: .....

Return to:  
Chairman John W. Sigler, M.D.  
P.O. Box 539  
Lansing 3, Michigan

(Turn to Page 160)



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## Other Meetings During MCI

TUESDAY, MARCH 7, 1961

**Michigan Chapter, American College of Surgeons**—all day meeting beginning at 9:00 a.m. in the English Room and followed by 6:00 p.m. reception and dinner in the Book-Casino, Sheraton-Cadillac Hotel, Detroit.

**Michigan Chapter, American Academy of Pediatrics**—all day meeting beginning at 9:30 a.m. in the Children's Hospital followed by 6:00 p.m. social hour and dinner in the English Room, Sheraton-Cadillac Hotel, Detroit.

Tuesday, March 7, 1961

Morning Session—9:30 a.m. to 12:00 M

Moderator: Robert M. Heavenrich, M.D., Chairman, Michigan Chapter AAP

A.M.

9:30 Registration

10:00 "The Nephrotic Syndrome in an Infant"—B. Khodadadeh, M.D. and Edgar Martner, M.D., Harper Hospital

10:20 (To be announced), Receiving Hospital

10:40 "de Toni Fanconi Syndrome"—Jay Bernstein, M.D. and Ruben Meyer, M.D., Children's Hospital, Detroit

11:00 "Salicylate Intoxication"—Donald Mason, M.D. and Arthur Tuuri, M.D., Hurley Hospital

11:20 "Peritoneal Dialysis"—Emily Magimity, M.D. and Paul Woolley, M.D., Children's Hospital, Detroit

11:40 "Protein Requirements of Infants and Children"—John Johnston, M.D., Gordon Manson, M.D., John Maroney, M.D., James Sweeney and Richard Brown, M.D., Henry Ford Hospital, Detroit

Luncheon—12:15 p.m. to 1:45 p.m.  
Children's Hospital, Detroit

Afternoon Session—2:00 p.m. to 5:00 p.m.

Moderator: Ruben Meyer, M.D., Alternate Chairman, Michigan Chapter AAP

P.M.

2:00 "Leukocyte Alkaline Phosphatase"—Beverly Jewell, M.D. and James Wilson, M.D., University Hospital, Ann Arbor

2:20 "Stenosis of the Left Lower Lobe Bronchus, Chronic Infection, Growth Failure"—Ronald Hoeksma, M.D. and Donald Waterman, M.D., Butterworth Hospital, Grand Rapids

2:40 "Coronary Rupture in a Child"—Rudolph M. Jarvi, M.D., Saginaw General Hospital, Saginaw

3:00 "Hospital Pediatric Services in Michigan"—Eugene Crawley, M.D., Director Child Health Services, Maternal and Child Health Section, State Health Department, Lansing

3:20 "Acute Hemocytic Anemia with Altafur Therapy"—Joseph Grayson, M.D. and Julius Rutzky, M.D., St. Joseph's Hospital, Pontiac

4:00 (To be announced)—Wolf Zuelzer, M.D., Children's Hospital

Evening Social Hour and Dinner—6:00 p.m.

P.M.

6:00 Social Hour—Sheraton-Cadillac Hotel, English Room (registration for Michigan Clinical Institute)

7:00 Dinner

8:30 "Trends in Immunizations"—James Wilson, Professor of Pediatrics, University of Michigan, Ann Arbor

**Michigan Epilepsy Center and Association**—5:30 p.m. reception-dinner-meeting in the Sheraton Room of the Sheraton-Cadillac Hotel, Detroit. Speaker is John Stirling Meyer, M.D., Detroit, Professor and Chairman, Department of Neurology, Wayne State University College of Medicine. Doctor Meyer will talk on "Cerebral Metabolism During Seizures and Post-Epileptic Paralysis." For dinner reservations, contact the Michigan Epilepsy Center and Association, 10 Peterboro, Detroit 1, FA 1-0105.

**Michigan Diabetes Association**—2:00 p.m. meeting followed by reception and dinner—all in the East and West Rooms of the Sheraton-Cadillac Hotel, Detroit.

Tuesday, March 7, 1961

Chairman: Ralph L. Fitts, M.D., Grand Rapids Chairman, Clinical Society

P.M.

2:00 "Methods of Detection of Diabetes Mellitus"—John B. Bryan, M.D., Detroit

2:20 "Importance of Early Detection of the Diabetic State"—Stefan S. Fajans, M.D., Ann Arbor

2:40 "Necessity of Careful Dietary Management of Diabetes"—Robert D. Johnson, M.D., Ann Arbor

3:00 "Insulin Therapy—Mixtures (Lente) and in Combination with DBI"—Fred W. Whitehouse, M.D., Detroit

3:20 Intermission

3:30 "The Oral Hypoglycemic Drugs"—Francis D. W. Lukens, M.D., Philadelphia, Pennsylvania

4:00 Panel Discussion on "Special Considerations in Diabetic Management"

Moderator: George C. Thosteson, M.D., Detroit  
Panelists: Stefan S. Fajans, M.D., Robert D. Johnson, M.D., Francis D. W. Lukens, M.D., and Fred W. Whitehouse, M.D.

Clinical Society—Annual Meeting

P.M.

6:30 Reception and Dinner

Chairman: Ralph L. Fitts, M.D., Grand Rapids  
Speaker: Francis D. W. Lukens, M.D., Philadelphia, Pennsylvania—"Comments on Ketogenesis"

**Michigan Academy of Physical Medicine and Rehabilitation**—6:30 dinner; 7:30 business meeting; 8:00 scientific program. Speaker, Jack Lapides, M.D., Associate Professor of Surgery, University of Michigan; topic, "Vesicostomy"—all in Room 1607 of the Sheraton-Cadillac Hotel.

# STATE SOCIETY

## WEDNESDAY, MARCH 8, 1961

**Michigan Medical Alumni Society**—12:00 p.m. reception and luncheon in the English Room of the Sheraton-Cadillac Hotel, Detroit.

**Michigan Committee on Trauma, American College of Surgeons and the Detroit Academy for the Surgery of Trauma**—12:00 noon reception-luncheon-meeting in the Sheraton Room of the Sheraton-Cadillac Hotel, Detroit.

**Michigan State Pharmaceutical Association**—dinner, 6:00 p.m. in the Sheraton Room of the Sheraton-Cadillac Hotel, Detroit (invitational).

**Board of Michigan Academy of General Practice**—12:00 noon luncheon-meeting in the Mason Room, Sheraton-Cadillac Hotel, Detroit.

## THURSDAY, MARCH 9, 1961

**Conference for Residents, Interns, Senior Students of Michigan**—2:00 p.m. in the English Room of the Sheraton-Cadillac Hotel, Detroit.

**Michigan Cancer Coordinating Committee**—12:30 p.m. luncheon in the Sheraton Room of the Sheraton-Cadillac Hotel, Detroit (invitational).

**Michigan Health Officers Association**—6:00 p.m. reception-dinner-meeting in the West Room of the Sheraton-Cadillac Hotel, Detroit. Speaker is Emily Sargent, R.N., Director, Detroit Visiting Nurse Association, who will talk on "Home Care of the Patient as Related to Nursing and Other Home Service."

**Operating Room Nurses Institute**—Thursday and Friday, March 9-10, 1961.

*Thursday, March 9, 1961*

8:00 a.m. to 4:00 p.m.

Registration—Mezzanine Floor, Sheraton-Cadillac Hotel

9:00 to 11:30 a.m.

Meeting—English Room, Sheraton-Cadillac Hotel

A.M.

9:00 Greetings: *Mrs. Harriett Bell*, Chairman, ORN Conference Group, MSNA

9:10 Presiding: *J. Jane Hannula*, Chairman, Program Committee, ORN Conference Group, MSNA  
"Security Is Everybody's Business"—*Avis J. Dykstra*, R.N., Assistant Executive Director, MSNA

10:00 Coffee Break

10:20 "Effective Personnel Policies Attract Valuable Employees"—*Russell Reister*, Personnel Director, University of Michigan Medical Center, Ann Arbor

11:30 a.m. to 2:00 p.m.

Lunch—visit exhibits on fourth floor of Sheraton-Cadillac Hotel

February, 1961

2:00 to 4:00 p.m.

Meeting—Detroit Leland Hotel  
"This Is Your Job, Employee"—Role Playing  
Presiding: *Helen Bozwick*, R.N., Detroit  
Employment . . . Orientation . . . Evaluation  
Question and Answer Period

*Friday, March 10, 1961*

8:00 a.m. to 4:00 p.m.

Registration—Mezzanine Floor, Sheraton-Cadillac Hotel

9:00 a.m. to 12:30 p.m.

Meeting—English Room, Sheraton-Cadillac Hotel

A.M.

9:00 Presiding: *Mrs. Jayne Robinson*, 2nd Vice Chairman, ORN Conference Group  
"The Present Status of Chemical Disinfection"—*Earle Spaulding*, Ph.D., Professor and Chairman, Temple University School of Medicine, Philadelphia, Pennsylvania

10:00 Coffee Break

10:20 Question and Answer Period

11:00 "Observations of Soviet Surgery"—*W. H. Steffensen*, M.D., Grand Rapids

12:30 to 2:00 p.m.

Luncheon—Colonial Ballroom, Detroit-Leland Hotel  
Presiding: *Mrs. Harriett Bell*  
"Another and a New Look"—"Operating Room Conference Group of the ANA"—*Sophia A. Larsen*, R.N., Chairman, ANA-ORN Conference Group

2:30 to 4:00 p.m.

Meeting—English Room, Sheraton-Cadillac Hotel

P.M.

2:30 Presiding: *Hazel Brown*, 1st Vice Chairman, ORN Conference Group  
"How to Plan a Central Supply Room"—*Mrs. Arlene Howe*, Erie, Pennsylvania, Nursing Consultant, American Sterilizer Company

3:15 "How Central Supply Room Services Operating Room and Other Hospital Units"—*Esther Anderson*, Central Supply Supervisor, Harper Hospital

2:30 Special Program for OR Clinical Instructors for Professional Student Nurses  
Presiding: *Wilda Rush*, R.N., Secretary, ORN Conference Group

4:00 Adjournment

## Michigan State Medical Assistants Society—

Fourth Annual Educational Seminar, 9:00 a.m. to 3:30 p.m. meeting at the Pick-Fort-Shelby Hotel, Detroit, Michigan.

*Thursday, March 9, 1961*

Theme: "Medical Techniques for Medical Assistants"

## STATE SOCIETY

*Morning Session—9:00 a.m. to 12 M*

A.M.

9:00 Registration—Crystal Room Foyer

10:00 Welcome

Mrs. Betty Lou Willey, President, Michigan State Medical Assistants Society

Introductions

Mrs. Esther G. Regnaert, Chairman of Seminar

10:15 The L. Fernald Foster Memorial Lecture—"Medical and Professional Ethics in the Doctors Office"—Donald N. Sweeney, Jr., M.D., General Surgeon, Detroit, Michigan, Director of Michigan Medical Service, and Michigan Cancer Foundation, MSMS Committee on Ethics

11:15 Film—"The Voice of Your Business"  
*Michigan Bell Telephone Company*

11:30 Movie—"The Invisible Enemy"  
*Civil Defense Production*

*Luncheon—12:15 p.m.*

Terrace Room

P.M.

1:30 "Understand the Purpose of Clinical Laboratory Procedures."—Alfred Golden, M.D., Pathologist, Director of Jennings Memorial and Alexander Blain Hospital Laboratories, Detroit, Michigan

2:30 "Radiation Hazards in Diagnostic and Therapeutic Radiology"—Robert S. Ormond, M.D., Radiologist, Department of Radiology, Henry Ford Hospital, Detroit, Michigan

3:30 Close

### FRIDAY, MARCH 10, 1961

**Operating Room Nurses Institute**—see complete program listed under Thursday, March 9.

**Michigan Society of Obstetrics and Gynecology**  
—2:30 to 4:30 p.m. meeting, 5:30 p.m. social hour, 6:30

p.m. banquet and evening program—all in the Grand Ballroom of the Sheraton-Cadillac Hotel, Detroit, except the social hour which will be held in the English Room.

**Michigan Heart Association**—6:30 p.m. dinner meeting in West Room, Sheraton-Cadillac Hotel, Detroit.

\* \* \*

**Wayne State University College of Medicine Alumni Association** will maintain an Alumni Headquarters suite in the Sheraton-Cadillac Hotel during the Michigan Clinical Institute. All alumni, their guests, and friends of Wayne State are cordially invited to visit the headquarters.

### Schedule of Meetings of MSMS Council for 1961

Tuesday, March 7	Sheraton-Cadillac Hotel, Detroit (preceding Michigan Clinical Institute)
Wednesday, April 19	MSMS Headquarters Bldg., East Lansing
Saturday, June 3	MSMS Headquarters Bldg., East Lansing
Thursday-Friday-Saturday, July 13-14-15	Mackinac Island
Sunday, September 24, and Thursday, September 28	Pantlind Hotel, Grand Rapids
Wednesday, November 15	MSMS Headquarters Bldg., East Lansing
Wednesday, December 13	MSMS Headquarters Bldg., East Lansing

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### Michigan Medical Meetings and Clinic Days

February 8-10	American Academy of Occupational Medicine	Statler Hotel, Detroit
March 8-10	Michigan Clinical Institute	Sheraton-Cadillac Hotel, Detroit
March 17	Michigan Society of Gerontology	Durant Hotel, Flint
April 6	Ingham County Clinic Day	Jack Tar Hotel, Lansing
April 26-29	American College Health Association	Detroit
April 27-29	American Academy of Neurology	Sheraton-Cadillac Hotel, Detroit
May 3	Wayne State University Clinic Day and Alumni Reunion	Fort Shelby Hotel, Detroit
May 22-25	Michigan Health Council	Flint Community College
June 16-17	Upper Peninsula Medical Society	Menominee
June 19-21	University of Michigan Conference on Aging	Ann Arbor
July 27-28	Coller-Penberthy Clinic	Park Place Hotel, Traverse City

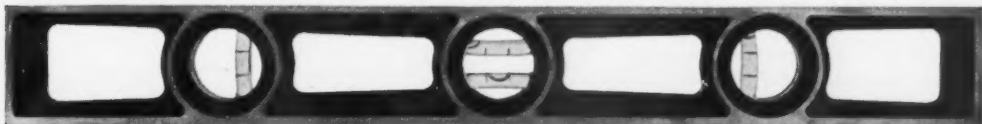
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# HIGHLIGHTS of The Council

## Meeting of December 14, 1960

A total of seventy-eight items was considered by The Council at its December meeting which was attended by 21 of the 23 members. Items of chief importance were:

- Progress report on new MSMS Headquarters Building was presented by President K. H. Johnson, M.D., who recommended that the dedication date be set for the first week in June. The Council decided on Sunday, June 4, for the formal dedication of the building. The matter of seeking memorial gifts was referred to the Big Look Committee for study and recommendation.
- Presidents Program. Resolution No. 25, adopted by the 1960 House of Delegates to institute the Presidents Program, was reviewed and The Council went on record as being highly in favor of the Presidents Program and recommended its early implementation by all involved—county medical societies, members, associations and organizations.
- Dates and places for 1961 meetings of The Council, nine in number, were decided.
- Wm. M. LeFevre, M.D., of Muskegon, Chairman of the County Secretaries Committee, reported on content of new Handbook for component society secretaries, to be distributed at the County Societies Seminar of January 28-29 in East Lansing.
- County-State Society Nights have been arranged by five component societies (Barry, Calhoun, Genesee, Muskegon, North Central), reported Council Chairman H. J. Meier, M.D., of Coldwater.
- Actions of the November, 1960 AMA House of Delegates Session were reported by Wm. A. Hyland, M.D., of Grand Rapids, Chairman of the Michigan Delegates to the AMA; the report, accepted with thanks, was referred to the Editor for publication in JMSMS.
- Appointments: Chairman Meier presented the personnel of Committees of The Council for 1960-61, which received approval; he also announced he had appointed Wm. Bromme, M.D., Detroit, as Chairman of Committee to Arrange 1961 Conference for Residents-Interns-Senior Medical Students, with Doctor Bromme to select members of the Committee; he reported that President Elect Otto K. Engelke, M.D., of Ann Arbor had been added to the Centennial Committee.

Howard G. Benjamin, M.D., Grand Rapids was chosen as General Chairman of Arrangements for

the 1961 MSMS Annual Session; Dr. Engelke was appointed MSMS representative to the Michigan Livestock Health Council so that the advice of medicine could be available when animal diseases communicable to man are being considered.

- The question of G. Thomas McKean, M.D., Detroit, President of Michigan Medical Service, re procedure to be used by MMS in referring mediation matters to county medical societies was decided by The Council: matters formerly referred to Councilor District Medical Care Insurance Committees now may be forwarded to the proper county medical society for referral to its own mediation or other appropriate committee.

Progress report on Michigan Medical Service was presented by President McKean who stated (a) that the question of Technical Surgical Assistants is still under study by the MMS Board of Directors; (b) that a new Public Relations Committee of MMS is working on a program to inform the public about its policies; (c) another Michigan Medical Service committee is working toward development of major medical coverage; (d) that 54% of federal employees under the new insurance program have chosen Blue Shield coverage.

- Committees of the House of Delegates. Speaker J. J. Lightbody, M.D., Detroit stated that, in accordance with Resolution 43 of 1960 MSMS House of Delegates, he had appointed the following committee to study problem of indigent doctors of medicine: Charles W. Sellers, M.D., Detroit, Chairman; Allison R. Vanden Berg, M.D., Grand Rapids; Perry C. Gittins, M.D., Detroit; and L. A. Drolett, M.D., Lansing; Doctor Lightbody also announced that, in accordance with Resolution 54 adopted in 1960 re revising the rules and order of business for the Annual Session, these recommendations will be implemented in the plans for the 1961 House of Delegates session.

The Speaker also reported appointment of the House of Delegates Committee to Review Constitutions and Bylaws; L. J. Bailey, M.D., Southfield, Chairman; R. R. Cooper, M.D., Grosse Pte.; A. B. Gwinn, M.D., Hastings; F. P. Rhoades, M.D., Detroit; J. A. Witter, M.D., Highland Park; and Lester P. Dodd, LL.B., ex officio, Detroit.

- 1961 MCI. The proposal of the MSMS Mental Health Committee (John M. Dorsey, M.D., Detroit, Chairman) to sponsor a program on care of

(Continued on Page 166)

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## Highlights of The Council

(Continued from Page 164)

aged patients in nursing homes, for Thursday evening, March 9 during the 1961 MCI, was approved by The Council.

- The 1960 MSMS House of Delegates approved the Annual Report of MSMS Committee on Study of Prevention of Highway Accidents which included recommendation that MSMS write to auto manufacturers deploring the present status of not incorporating more safety features in their products. Draft of a letter on this subject by John R. Rodger, M.D., Bellaire, Chairman of the Committee, was authorized to be sent to auto manufacturers, with contents to be released to the public.
- The recommendation of the Wayne County Medical Society that there be only one group health and accident plan and one group life insurance plan for all physicians in Michigan was referred to the MSMS Committee on Insurance for study and report back to The Council.
- O. B. McGillicuddy, M.D., of Lansing, Chairman of the Finance Committee, reviewed the monthly Financial Report and other items considered by the Finance Committee at its December 14 meeting, including purchase of new dictating equipment, cleaning arrangement for new MSMS building, and expense of inviting county society representatives to January 12 MSMS Maternal Health Committee meeting.
- Lester P. Dodd, LL.B. of Detroit, MSMS Legal Counsel, reported on a number of matters including (a) mail order practice of handling laboratory work for doctors; (b) exemption of doctors from jury service; (c) ethics and legality of physicians taking listings in yellow pages of telephone directory in an adjoining county in which physician does not reside; (d) necessity for obtaining a doctor's consent for release of information on a patient by Social Security Administration to a local county Bureau of Social Aid; (e) liability when a druggist refills a prescription without a doctor's knowledge or consent; (f) surgical consent forms.
- Public Relations Counsel Report included presentation of second issue of *Medical Economic Currents*, report on career conferences; plans for 1961 Michigan Clinical Institute news conference; reprinting of pamphlet "In Planning Your Career"—10,000 copies being authorized; resignation of Mr. Richard N. Philleo as MSMS Field Secretary and employment of Morris A. Riley.
- Committee Reports: The following were given consideration: (a) ad hoc Committee Concerning

Practice of Chiropractic, meeting of October 6; (b) Michigan Clinical Institute Program Committee, October 18; (d) Maternal Health Committee, October 20; (e) Michigan Clinical Institute Television Committee, October 20 and November 3; (f) Geriatrics Committee, November 15; (g) Mental Health Committee, November 22; (h) Committee on Scientific Work, November 23; (i) Advisory Committee to Executive Director, December 14.

- Michigan Health Commissioner A. E. Heustis, M.D., distributed copies of "Health Service for Michigan People, 1961" which contained digest of new items in State Health Department budget request, together with overall summary of the request.
- Reports from G. E. Millard, M.D., Detroit, on national meeting of American Association of Medical Assistants held in Dallas, Texas; from C. P. Anderson, M.D., Detroit, on the 11th County Medical Societies' Conference on Disaster Medical Care held in Chicago; from Richard N. Philleo on November 27 meeting on care of the aged held in Washington, D. C.
- MSMS representatives to (a) AMA Medical Legal Conference Regional meeting: Legal Counsel Dodd was authorized to attend this April meeting if he so desires; (b) Professional Convention Management Association: Executive Director Wm. J. Burns was authorized to attend this January meeting if he so desires.

## MSMS Cooperates

The Michigan State Medical Society will be represented on the new Michigan Livestock Health Council by President-Elect Otto K. Engelke, M.D., Ann Arbor.

Organized in December, the Council is designed to study livestock diseases communicable to man, make recommendations on regulatory education and research programs, plan and implement statewide health programs and to review progress in this field. The 48-member council includes representatives from other associations concerned with health, agriculture, marketing and veterinary and human medicine.

## Co-sponsor Course at U-M

A Postgraduate Course in Rheumatic Fever, Rheumatic Heart Disease and Congenital Heart Disease will be presented at the University of Michigan Medical Center, March 13-17. Outstanding speakers have been obtained for this course, co-sponsored by the Michigan Heart Association, University of Michigan Medical Center, Wayne State University College of Medicine and the Michigan State Medical Society.



in infectious disease<sup>17,22,30,38</sup>  
in arthritis<sup>18,19,20,28</sup>  
in hepatic disease<sup>2,3,4,5,38</sup>  
in malabsorption syndrome<sup>1,2,6,27</sup>  
in degenerative disease<sup>6,7,19,20,40</sup>  
in cardiac disease<sup>23,26,29,38,41</sup>  
in dermatitis<sup>24,39</sup>  
in peptic ulcer<sup>9,21,38</sup>  
in neuroses & psychiatric disorders<sup>25,38</sup>  
in diabetes mellitus<sup>31,32,33,38</sup>  
in alcoholism<sup>9,11,33,37,38</sup>  
in ulcerative colitis<sup>10,14,16</sup>  
in osteoporosis<sup>13,19,20</sup>  
in pancreatitis<sup>19</sup>  
in female climacteric<sup>12,34</sup>

**Patients with chronic disease deserve  
the nutritional support provided by**

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Squibb Vitamin-Minerals for Therapy

**11 vitamins, 8 minerals  
clinically-formulated and potency  
protected to provide  
enough nutritional support  
to do some good**

**with vitamins only**

**Theragran  
also available:**

**Theragran Liquid  
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Theragran products do not contain folic acid.

1-41 a list of the above references will be supplied on request.

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**Squibb Quality—the Priceless Ingredient**

# What is your goal...

*in helping physically handicapped  
patients toward recovery?*

The Rehabilitation  
Institute  
of  
Chicago  
Offers Three  
Possibilities:



*return to normal.*



*moderate disability  
but able to work.*



*severely disabled but not  
totally incapacitated.*

*...through comprehensive  
rehabilitation for*

- hemiplegia
- paraplegia
- quadriplegia
- amputations
- degenerative diseases of the nervous system
- traumatic disabilities of the hand
- arthropathies

*Services Available  
for both in and  
out patients:*

- Medical Care
- Nursing Care
- Laboratory Services
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Medical Social Service
- Vocational Counseling
- Psychological Service

*Admission on Medical Referral Only—Referring physician has courtesy staff privileges, receives regular interim reports, complete summary at discharge, and a recommended program for continued treatment.*

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Bernard J. Michela, M.D.  
Director

ANNOUNCING—  
SPECIFICALLY FOR  
INFECTIONS DUE TO  
“RESISTANT” STAPHYLOCOCCI

AN ENTIRELY NEW SYNTHETIC  
“STAPH-CIDAL” PENICILLIN

Staphcillin<sup>TM</sup>  
sodium dimethoxyphenyl penicillin  
FOR INJECTION

UNIQUE—BECAUSE IT  
RETAINS ANTIBACTERIAL  
ACTIVITY IN THE PRESENCE OF  
STAPHYLOCOCCAL PENICILLINASES  
WHICH INACTIVATE  
OTHER PENICILLINS



## MICROBIOLOGICAL AND PHARMACOLOGICAL PROPERTIES

*In vitro* studies show that STAPHICILLIN is a bactericidal penicillin with activity against staphylococci resistant to penicillin G. Strains of staphylococci so far tested have been sensitive to STAPHICILLIN *in vitro* at concentrations of 1-6 mcg. per ml. These levels are readily attained in the blood and tissues by administration of STAPHICILLIN at the recommended dosage. This unique attribute is probably due to the fact that STAPHICILLIN is stable in the presence of staphylococcal penicillinase. STAPHICILLIN also resists degradation by *B. cereus* penicillinase. The antimicrobial spectrum of STAPHICILLIN with regard to other microorganisms is qualitatively similar to that of penicillin G; but considerably higher concentrations of STAPHICILLIN are required for bactericidal activity than is the case with penicillin G.

STAPHICILLIN is rapidly absorbed after intramuscular injection. Peak blood levels (6-10 mcg./ml. on the average after a 1.0 Gm. dose) are attained within 1 hour; and then progressively decline to less than 1 mcg. over a 4 to 6 hour period. It is poorly absorbed from the gastrointestinal tract. STAPHICILLIN is rapidly excreted by the kidney.

As shown by animal studies, STAPHICILLIN is readily distributed in body tissues after intramuscular injection. Of the tissues studied, highest concentrations are reached in the kidney, liver, heart and lung in that order; the spleen and muscles show lower concentrations of the antibiotic. STAPHICILLIN diffuses into human pleural and prostatic fluids, but its diffusion into the spinal fluid has not yet been completely studied. However, one patient with meningitis showed a significant concentration in his spinal fluid while on STAPHICILLIN therapy.

Toxicity studies with STAPHICILLIN and penicillin G in animals show that they have approximately the same low order of toxicity.

Certain staphylococci can be made resistant to STAPHICILLIN in the laboratory, but this resistance is not related to their penicillinase production. During the clinical trials, no STAPHICILLIN-resistant strains of staphylococci were observed or developed; the possibility of the emergence of such strains in the clinical setting awaits further observation.

## PRECAUTIONS

During the clinical trials, several mild skin reactions, e.g., itching, papular eruption and erythema were observed both during and after discontinuance of STAPHICILLIN therapy. Patients with histories of hay fever, asthma, urticaria and previous sensitivity to penicillin are more likely to react adversely to the penicillins. It is important that the possibility of penicillin anaphylaxis be kept in mind. Epinephrine and the usual adjuvants (antihistamines, corticosteroids) should be available for emergency treatment. Because of the resistance of STAPHICILLIN to destruction by penicillinase, parenteral *B. cereus* penicillinase may not be effective for the treatment of allergic reactions. Information with regard to cross-allergenicity between penicillin G, penicillin V, phenethicillin (Syncillin) and STAPHICILLIN is not available at present. If superinfection due to Gram-negative organisms or fungi occurs during STAPHICILLIN therapy, appropriate measures should be taken.

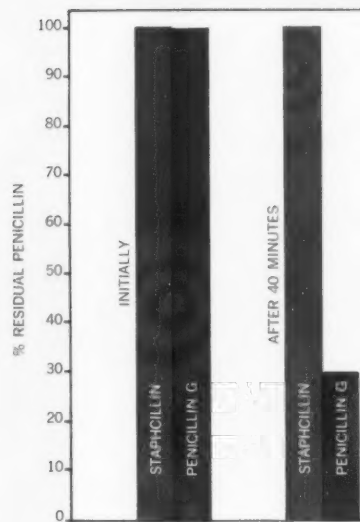
## SUPPLY

List 79502 — 1.0 Gm. dry filled vial.

BRISTOL LABORATORIES • SYRACUSE, NEW YORK  
Division of Bristol-Myers Company

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UNIQUE SYNTHETIC "STAPH-CIDAL" PENICILLIN



# Specifically for Staph

The failure of staphylococcal infection to respond to the penicillin-destroying enzyme, penicillinase.

Unlike other penicillins:

- 1 STAPHICILLIN is effective because of its resistance to the action of penicillinase, the enzyme of staphylococcal penicillinase.
- 2 The clinical effectiveness of STAPHICILLIN in the treatment of a wide variety of infections due to staphylococci, which are often life-threatening.

Like other penicillins:

STAPHICILLIN has no significant local or systemic pain or irritation at the injection site. It is also effective against penicillin G. *In occasional cases,*

PROFESSIONAL INFORMATION: For complete information on the indications, dosage, and additional information concerning clinical use of STAPHICILLIN, contact Bristol Laboratories at your service, Yonkers, N.Y. PLaza 7-7061, or by mail to Medical Department, Bristol Laboratories, Inc., P.O. Box 100, Yonkers, N.Y.

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In the presence of staphylococcal penicillinase, STAPHICILLIN remained active and retained its antibacterial action. By contrast, penicillin G was rapidly destroyed in the same period of time.  
(After Gourevitch et al., to be published)

or "resistant" staph...

# staphicillin<sup>TM</sup>

sodium dimethoxyphenyl penicillin  
FOR INJECTION

Infections that do not respond to penicillin therapy is attributed to the presence of penicillinase, produced by the invading staphylococcus.

STAPHICILLIN is effective because it retains its antibacterial activity despite the presence of penicillinase.

The effectiveness of STAPHICILLIN has been confirmed by dramatic results in the treatment of "resistant" staphylococci, many of which were serious

infections. Significant systemic toxicity. It is well tolerated locally, and the reaction site is comparable to that following the injection of penicillin. In some cases, typical penicillin reactions may be experienced.

**FOR SERVICE** — The attached Official Package Circular provides complete instructions, dosages, and precautions for the use of STAPHICILLIN. If you desire more clinical experiences with STAPHICILLIN, the Medical Department of Bristol Laboratories is at your service. You may direct your inquiries via collect telephone call to New York, N. Y. Medical Department, Bristol Laboratories, 630 Fifth Ave., N. Y. 20, N. Y.

**BRISTOL LABORATORIES • SYRACUSE, NEW YORK**

Division of Bristol-Myers Company

OFFICIAL PACKAGE CIRCULAR  
November, 1960

## STAPHCILLIN™

(sodium dimethoxyphenyl penicillin)

For Injection

### DESCRIPTION

STAPHCILLIN is a unique new synthetic parenteral penicillin produced by Bristol Laboratories for the specific treatment of staphylococcal infections due to resistant organisms. Its uniqueness resides in its property of resisting inactivation by staphylococcal penicillinase. It is active against strains of staphylococci which are resistant to other penicillins.

*Each dry filled vial contains:* 1 Gm. STAPHCILLIN (sodium dimethoxyphenyl penicillin), equivalent to 900 mg. dimethoxyphenyl penicillin activity.

### INDICATIONS

STAPHCILLIN is recommended as specific therapy only in infections due to strains of staphylococci resistant to other penicillins, e.g.:

*Skin and soft tissue infections:* cellulitis, wound infections, carbuncles, pyoderma, furunculosis, lymphangitis and lymphadenitis.

*Respiratory infections:* staphylococcal lobar or bronchopneumonia, and lung abscesses combined with indicated surgical treatment.

*Other infections:* staphylococcal septicemia, bacteremia, acute or subacute endocarditis, acute osteomyelitis and enterocolitis.

Infections due to penicillin-sensitive staphylococci, streptococci, pneumococci and gonococci should be treated with Syncillin® or parenteral penicillin G rather than STAPHCILLIN. Treponemal infections should be treated with parenteral penicillin G.

### DOSAGE AND ADMINISTRATION

STAPHCILLIN is well tolerated when given by deep intragluteal or intravenous injection.

As is the case with other antibiotics, the duration of therapy should be determined by the clinical and bacteriological response of the patient. Therapy should be continued for at least 48 hours after the patient has become afebrile, asymptomatic and cultures are negative. The usual duration has been 5-7 days.

*Intramuscular route:* The usual adult dose is 1 Gm. every 4 or 6 hours. Infants' and children's dosage is 25 mg. per Kg. (approximately 12 mg. per pound) every 6 hours.

*Intravenous route:* 1 Gm. every 6 hours using 50 ml. of sterile saline solution at the rate of 10 ml. per minute.

\**Warning:* Solutions of STAPHCILLIN and kanamycin should not be mixed, as they rapidly inactivate each other. Data on the results of mixing STAPHCILLIN with other antibiotics are being accumulated.

### DIRECTIONS FOR RECONSTITUTION

Add 1.5 ml. sterile distilled water or normal saline to a 1 Gm. vial and shake vigorously. Withdraw the clear, reconstituted solution (2.0 ml.) into a syringe and inject. The reconstituted solution contains 500 mg. of STAPHCILLIN per ml. Reconstituted solutions are stable for 24 hours under refrigeration.

For intravenous use, dilute the reconstituted dose in 50 ml. of sterile saline and inject at the rate of 10 ml. per minute.

\*This statement supersedes that in the Official Package Circulars dated September and/or October, 1960.

(continued)

## The Importance of the Public Image Versus Reality

Excerpts of an address by Pierre D. Martineau, Director of Research and Marketing, Chicago Tribune, at the AMA Public Relations Institute, September 1, 1960, Chicago.

Whenever new ideas appear which attain wide currency, they seem to go through a cycle and eventually become popularized and bastardized.

Very often the public becomes so fatigued hearing about them that it pretends they have lost their validity. Nevertheless, the original force of the concept still remains. I could mention psychoanalysis, evolution, and relativity just as examples. The concept of the image of a brand, a product category, an organization, a profession, or an idea seems to be going through the same cycle.

However much you have encountered this, it is still important to realize exactly what is meant by the public image of doctors and the AMA because in very large measure this will play a key role in the future course of political and public behavior involving you people.

\* \* \*

MY ROLE HERE is to lay a theoretical groundwork for subsequent discussion of the subject. In order to proceed from the concrete to the abstract and to make perfectly clear what I am driving at, let me recite some workaday experiences with very mundane things.

Westclox introduced a wrist watch which is not selling very well. Why? Because the associations in people's mind of Westclox are those of big alarm clocks, not beautiful watches. They sought to open new channels of distribution by selling them through drug stores. What kind of watches are customarily sold in drug stores? Mickey Mouse watches and cheaper watches like Timex.

The Simoniz Company has embarked on a program of diversification with only indifferent success. Why? Because in the public mind Simoniz is tied to associations of a hard, tough wax. Too many people recall long hours of hard work helping their fathers Simoniz the family car.

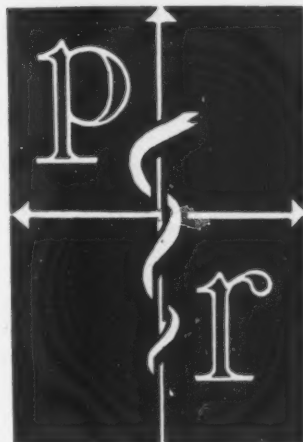
\* \* \*

THE POINT I AM TRYING to make is that every well-known brand is defined in the public mind by what it is and most importantly by sets of psychological associations which may or may not be true. Both of these constitute the brand image and it is this image that humans react to rather than reality. All of our stimuli from the outside are filtered through this image.

I have talked about individual brands. But the same things are true of whole product categories. The margarine makers have made perfectly clear that their product is fortified by vitamins to have all the food value that butter has, it has many advantages of use, and it costs only half as much. If it is colored, so is butter. But there is still more butter sold than margarine because of the associa-

PUBLIC RELATIONS

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tions tied to margarine versus these country-charm and quality notions attached to butter.

At some point in time for the individual, these images are formed, partly by experience but mostly by word of mouth. Once they are formed, they become stereotypes extremely difficult to alter. It is these images people have which far more often determine their behavior than the actualities. We bend the actualities to fit the image. We believe what we want to believe.

\* \* \*

THIS IS ONE OF THE fallacies in our heritage of rationality—that if we give people the facts, then we will win our case. “Know the truth and the truth shall make ye free” is handed down to us as a credo. But any deep-set image becomes more and more embedded in feeling. And you rarely change people’s feelings by presenting them information, which rarely gets to their feelings.

Sophisticated American marketers today realize that even though most products in the same category are relatively indistinguishable, consumers have different images which determine their purchasing. Although they in laboratory conditions cannot tell the difference between cigarettes or liquor or detergents or bread, they firmly believe there are differences once they see the products labelled.

\* \* \*

IF MY THESIS SEEMS an unkind commentary on an educated, high-stage civilization such as ours, the truth is we prefer to act toward our illusions. I don’t suppose 5% of the stars in Hollywood and on TV use their own names. Their agents adorn them with romantic names which transmute their images. Even when I know that Rock Hudson was born Roy Fitzpatrick, I still act toward him as Rock Hudson. In other words, the semblance of truth is more important than truth itself.

This does not mean these images cannot be modified. Of course they can. Chevrolet a few years ago discovered its image was that of an uninteresting, old folks, low price car with none of the associations attached to the up-and-coming Ford such as smartness, youthfulness, modernity, the epitome of modern suburbia. But Chevy—no longer Chevrolet—transmuted its image into something entirely different. In this model year Chevy sales were twice those of Ford. Pepsi Cola changed itself from a cheap soft drink into the image of lightness and the modern young wife.

But in this attempt to change an image, the most common error I encounter is the belief that we can cure public misunderstanding merely by supplying information which is usually directly contrary to what people believe and feel.

After a study in 1954 revealed that 57% of American adults did not even know what a common stock

was, the New York Stock Exchange embarked on a program of “public education.” After 6 years of “education,” another study has just been completed which showed that now 56% of American adults did not know what a common stock was. Another study of stockholders revealed that 57% of them could not name one single product manufactured by the companies in which they owned stock. Yet Wall Street complacently feels it has changed its image. I don’t think it has at all. The public has simply found another villain it dislikes worse than Wall Street: Madison Avenue.

\* \* \*

THEREFORE, IN CLOSING, I would state you have your work cut out for you, in view of the hostilities I seem to encounter among highly educated people. In both cases you have two factors: doctors as they really are, and doctors as the public sees them; the American Medical Association as it is and the image of the AMA which is held by the public, the politicians and the influential intellectuals. I hope I have made it clear that you cannot hold up your hands in anger and say that’s not the way you really are. It is all imperative that you come to grips with these images of the doctor and of the AMA.

### *Present Family Doctor TV Show in Lansing*

A special one-hour telecast demonstrating the various activities in a doctor’s office was presented recently over WMSB, Channel 10, Lansing. Cooperating were the MSMS, Ingham County Medical Society and the Michigan Health Council.

Television cameras took viewers through a general physical examination and a surgical procedure. An examination for breast cancer, application and removal of a cast and a demonstration of what happens when the mother-to-be makes her monthly visit to the doctor were included.

The presentation was the fourth in a series. The first show was staged in Detroit with the Wayne County Medical Society, the second in cooperation with the Kalamazoo Academy of Medicine, the third with the Kent County Medical Society.

The Lansing show featured David Siegel, M.D., as medical moderator, describing the actions and interviewing the participants: Frederick C. Swartz, M.D.; John H. Packer, M.D.; Richard W. Pomeroy, M.D.; E. J. Robson, M.D.; and M. S. Sharp, M.D., assisted by Mrs. Irene Helms, medical technician.

Summing up the hour-long special feature was MSMS President Kenneth H. Johnson, M.D., who explained that the purpose of the show “was to provide a clearer understanding of good medicine as practiced in a doctor of medicine’s office.”

combine  
two basic  
approaches  
to angina  
pectoris...

**ALLAY ANXIETY... PROMOTE VASODILATION**



and see  
if you  
don't get  
a response  
like this:

**CARTRAX REDUCES "LENGTH, SEVERITY AND  
AMOUNT OF ANGINA PECTORIS" IN ANXIOUS CARDIACS\***

Clark treated 31 anginal patients who showed signs of anxiety, fear, excitement and other forms of emotional stress. On CARTRAX, all 31 fared better than they had on previous therapy... as judged both by subjective reports and by reduced nitroglycerin requirements.\*

CARTRAX combines PETN (for prolonged vasodilation) with ATARAX (the tranquilizer preferred for angina patients because of its safety and mild antiarrhythmic properties). Thus, CARTRAX helps you to cope with both components of angina pectoris—circulatory and emotional.

For a better way to help your angina patients relax, prescribe CARTRAX.

\*Clark, T. E., in press.

# CARTRAX®

**PETN<sup>†</sup> + ATARAX®**

**Dosage:** Begin with 1 to 2 yellow CARTRAX "10" tablets (10 mg. PETN plus 10 mg. ATARAX) 3 to 4 times daily. For dosage flexibility, CARTRAX "20" (pink) tablets (20 mg. PETN plus 10 mg. ATARAX) may be utilized at a level of one tablet three to four times a day. The tablets should be administered before meals for optimal response. For convenience, write "CARTRAX 10" or "CARTRAX 20." As with all nitrates, use with caution in glaucoma.

**Supplied:** In bottles of 100. Prescription only.

<sup>†</sup>Pentaerythritol tetranitrate <sup>††</sup>brand of hydroxyzine



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Science for the World's Well-Being™



# ATHEMOL<sup>®</sup>

magnesium 3, 7-dimethyl-xanthine oleate

**INDICATIONS:**

Arteriosclerosis and its consequences:  
hypercholesteremia, atherosclerosis, cerebral sclerosis,  
xanthomatosis, etc.

An effective aid for symptomatic treatment of arteriosclerosis. Athemol improves the circulation and well-being of the patient. Favorable response in patients with such symptoms as vertigo, mental confusion, chest pain, headaches, etc., often observed within a one or two-month period.

**DOSAGE:**

One or two tablets t.i.d. Available in tablets of 200 mg. each. Athemol is easily tolerated, and can be administered safely over a prolonged period.

**REFERENCES:**

(1) Buck, R. C.: Minerals of Normal and Arteriosclerotic Aortas, Arch. Path., 51, 1951. (2) N. Ressler, et al.: Relation of Serum Stability to the Development of Arteriosclerosis, Amer. J. Clin. Path. vol. 24, 1954. (3) S. D. Jacobson, M.D., Wayne County General Hospital, Eloise, Michigan. To be published. (4) Prof. V. Patzelt, Untersuchungen über die Veränderung der Bluteiweiß-Körper mit Mag. 3, 7-dimethyl-xanthine oleate, Klin. Med. 5, 11, 1956. (5) Dr. J. Skursky, Wiener Med. Wochenschrift, 1953, Nr 46, S. 886-887. (6) Eduard Keeser, M.D. and K. F. Benitz, M. D., Med. Klin. 1953 Nr. 15.



**MEYER LABORATORIES**  
Detroit, Michigan

## Hospital Admissions Up 75 Per Cent Since '40

A study of hospital records reveals that admissions to general and special hospitals in the United States increased from 74 per 1,000 persons in 1940 to 130 per 1,000 during 1959.

Advances in medical science, however, helped reduce the lengths of stay from an average of 13.7 days in 1940 to 9.6 days in 1959. This decrease was the leading reason why the number of days in all hospitals for each 1,000 persons declined slightly from 2,839 in 1940 to 2,811 in 1959.

Although the hospital admission rates are 75 per cent higher than 20 years ago, the days in hospital per person for the total population was the same for 1940 as 1959.

The average number of days each American spent in general and special hospitals, mental hospitals, and special tuberculosis hospitals was the same in 1959 as in 1940, down after a peak of 3.9 days a person in the wartime year of 1945, and an average of 3.1 days a person in 1951, 1952 and 1953.

The reduction in the length of hospital stays played a key role in keeping the demand for hospital services within manageable bounds. If the average length of stay in general and special hospitals had remained at its 1940 level of 13.7 days through 1959, the rise in admissions would have produced 1,789 days in these hospitals for each 1,000 persons, some 43 per cent above the actual figure of 1,254 days.

These figures are from a report of the Health Insurance Institute.

\* \* \*

### Says Final "Kintner" Regulations Disappointing

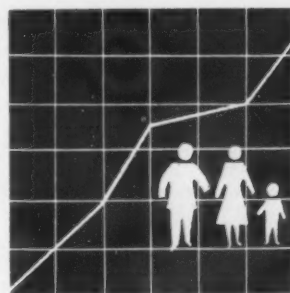
The long awaited Regulations for "Kintner" type associations have now been issued in final form by the Internal Revenue Service, reports the AMA Law Department.

Physicians who looked forward to qualifying for tax-deferred pension plans through the establishment of unincorporated medical groups taxable as corporations will in most instances be disappointed, says the AMA law department.

In the Kintner and Galt cases, it was held that even though under local laws doctors and other professional persons cannot form a corporation, these laws do not necessarily prevent an association of doctors from being taxed as a corporation under the Internal Revenue Code. The court in each case held that the clinic involved more nearly resembled a corporation than a partnership and therefore the physicians in the group could participate in a tax-deferred pension plan.

The AMA Law Department says it was hoped that the Regulations would implement the holdings in the Kintner and Galt decisions. However, in the opinion of the AMA Law Department, the Regulations amount to non-acquiescence on the part of the Commissioner.

## SOCIO ECONOMICS 177



The Regulations state that an unincorporated organization shall not be classified as an association unless it has more corporate than non-corporate characteristics. The extent to which the following incorporated characteristics are present or absent will determine whether an organization will be classified as a partnership or an association: (1) continuity of life, (2) centralization of management, (3) limitation of liability for debts to organization property, that is, no personal liability on the part of members, and (4) free transferability of interests.

### **Health Care of the Aged— What Insurance Industry is Doing**

With public interest in this problem at an all time high, one might well ask what our private insurance industry is doing about it. "Seven Principal Methods" are being employed currently by insurance companies to provide the aged with medical and hospital care expense. They are:

1. The continuation of insurance on older active workers under group insurance.
2. The continuation of group insurance on retired workers and their dependents, generally with part or all of the premium paid by the employer.
3. The continuation on an individual policy basis of coverage originally provided by group insurance by virtue of the right on the part of the employee to convert his group coverage.
4. The new issuance of group insurance at advanced ages, to such groups as associations of retired persons, retired civil servants or Golden Age Clubs.
5. The continuation into later years of individual insurance purchased in the productive years, with at least 51 insurance companies writing coverages guaranteed renewable for life.
6. The new issuance of individually purchased policies at advanced ages, with at least 165 insurance companies issuing policies at age 65 and over.
7. The issuance of insurance that becomes paid-up for life at age 65.

—Quoted from Query, publication of the American Society of Chartered Life Underwriters (December number).

Specialists of the Chamber of Commerce of the United States estimate that by next December, seven out of ten of the aged needing and wanting hospital-surgical insurance will be covered by such policies. By 1969, nine out of ten persons will be so insured, they predict.

### **A Word to the Wise**

All doctors of medicine are advised to make sure that they have the proper receipts and vouchers to substantiate income tax deductions for entertainment and travel expenses. The Internal Revenue Service has added additional information requirements on Schedule C of the return. Apparently, these deductions will be spotlighted by government auditors when your return is checked. It is possible that it might be a couple of years before they get around to discussing the matter with you, so it is best to keep a good record of your expenditures in this area. If you have not kept good records, go back and try to secure receipts wherever possible while the matter is still fresh in your mind. Remember when Uncle Sam does talk to you, you have the burden of sustaining the deductions.

—Illinois State Medical Society Newsletter,  
No. 31.

### **Blue Shield Payments to Doctors Reach All Time High in 1960**

More than 1,847,000 persons enrolled in the 74 Blue Shield Plans located in North America during the first nine months of 1960, and during the same period the Plans paid out approximately \$550,000,000 for care rendered to members.

"Of special significance is the fact that the \$550,000,000 paid to physicians was an all-time high in payments for a nine-month period, and represented approximately 91 per cent of the total income of all Blue Shield Plans," the national association indicated in its report. At the same time, the 74 Blue Shield Plans were reported to have expended less than 10 per cent of total income for administrative expenses.

The national association also said in its report that membership in the 74 Plans reached 46,640,348 as of September 30, 1960—an enrollment of one out of every four Americans. Included in the enrollment figures for the first time are approximately 938,000 Federal workers who selected Blue Shield under the recently enacted Federal Employees Health Benefits Program.

Texas Society of Internal Medicine adopted a relative value schedule at its first annual meeting.

# ANNOUNCING A CHANGE IN NAME

without change in formula or patient benefits

Centalex is  
now  
called  
**elixir**

# cenalene

Trademark

a cerebral tonic-stimulant fortified with neurotropic vitamins



**helps the geriatric patient  
return from the shadow-  
land of senility**

To improve mental function  
and behavior patterns in  
the geriatric patient, Elixir

CENALENE provides the cerebral-stimulating  
action of **pentylene-tetrazol** fortified with  
**thiamine, niacinamide, and vitamin B<sub>12</sub>**.  
Specifically counteracts typical symptoms of  
degenerative changes in the central nervous  
system of elderly patients, particularly those  
with cerebral arteriosclerosis...and can be  
given indefinitely to responsive patients be-  
cause of low incidence of side effects or  
toxicity in usual effective dosage.

Patients are helped to make better social  
adjustments...to lead happier, more useful  
lives...and to become **less of a problem** to  
themselves, relatives, or institutions.

**Each teaspoonful (5 ml.) contains 100 mg.**  
Cenalene (brand of pentylene-tetrazol), 1.67  
mg. thiamine HCl, 7.5 mg. niacinamide, and  
2.5 mcg. cyanocobalamin (vitamin B<sub>12</sub>);  
alcohol, 15%. **Available** in bottles of one pint  
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*Literature on request*



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*Products Born of Continuous Research*  
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## **Proven**

in more than 750 published clinical studies

## **Effective**

for relief of anxiety and tension

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- 1 simple dosage schedule produces rapid, reliable tranquilization without unpredictable excitation
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# **Miltown<sup>®</sup>**

meprobamate (Wallace)

*Usual dosage:* One or two 400 mg. tablets t.i.d.

*Supplied:* 400 mg. scored tablets, 200 mg. sugar-coated tablets.

Also as MEPROTABS<sup>®</sup>—400 mg. unmarked, coated tablets; and as MEPROSPAN<sup>®</sup>—400 mg. and 200 mg. continuous release capsules.



WALLACE LABORATORIES / Cranbury, N. J.

# of clinical use...

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## ...for the tense and nervous patient

Despite the introduction in recent years of "new and different" tranquilizers, Miltown continues, quietly and steadfastly, to gain in acceptance. Meprobamate (Miltown) is prescribed by the medical profession more than any other tranquilizer in the world.

The reasons are not hard to find. Miltown is a *known* drug. Its few side effects have been fully reported. ***There are no surprises in store for either the patient or the physician.***

NEW analgesic

Kills pain



# stops tension

For neuralgias, dysmenorrhea, upper respiratory distress, postsurgical conditions...new compound kills pain, stops tension, reduces fever—gives more complete relief than other analgesics.

Soma Compound is an entirely new, totally different analgesic combination that contains three drugs. First, Soma: a new type of analgesic that has proved to be highly effective in relieving both pain and tension.\* Second, phenacetin: a "standard" analgesic and antipyretic. Third,

caffeine: a safe, mild stimulant for elevation of mood. As a result, the patient gets more complete relief than he does with other analgesics.

Soma Compound is nonnarcotic and nonaddicting. It reduces pain perception without impairing the natural defense reflexes.\*

## NEW NONNARCOTIC ANALGESIC

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**Composition:** Soma (carisoprodol), 200 mg.; phenacetin, 160 mg.; caffeine, 32 mg.

**Dosage:** 1 or 2 tablets q.i.d.

**Supplied:** Bottles of 50 apricot-colored, scored tablets.

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**BOOSTS THE EFFECTIVENESS OF CODEINE:** Soma Compound boosts the effectiveness of codeine. Therefore, only  $\frac{1}{4}$  grain of codeine phosphate is supplied to relieve the more severe pain that usually requires  $\frac{1}{2}$  grain.


**Composition:** Same as Soma Compound plus  $\frac{1}{4}$  grain codeine phosphate.

**Dosage:** 1 or 2 tablets q.i.d.

**Supplied:** Bottles of 50 white, lozenge-shaped tablets; subject to Federal Narcotics Regulations.

\*References available on request.

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it's clear...

in sinusitis, colds  
and upper respiratory  
disorders

NEW

**DIMETAPP<sup>®</sup> Extentabs<sup>®</sup>**

let your patients  
breathe easier!



In sinusitis, colds and other upper respiratory and allergic disorders, new DIMETAPP Extentabs offer more useful decongestant therapy. Stuffiness, drip and other annoying symptoms of congestion are effectively relieved with minimum side effects.

**UNSURPASSED RELIEF OF NASAL CONGESTION** DIMETAPP Extentabs contain an unexcelled antihistamine, Dimetane, which has produced good to excellent results in thousands of cases of allergic respiratory disorders.\* In DIMETAPP Extentabs, the action of Dimetane with two outstanding decongestants—phenylephrine and phenylpropanolamine—promptly dries secretions and reduces edema and congestion in the nose, the sinuses, and the upper respiratory tract.

**CLEAR BREATHING FOR 12 HOURS ON 1 TABLET** Long-acting DIMETAPP Extentabs offer up to 12-hour relief on just one tablet. Easier to use than nose drops or sprays,

DIMETAPP reaches into areas topical decongestants can't touch—without rebound congestion.

**EXCEPTIONAL FREEDOM FROM SIDE EFFECTS** With DIMETAPP Extentabs, there's little problem of either drowsiness or overstimulation. The antihistamine component, Dimetane, offers a high percentage of effective relief with only drowsiness as a possible infrequent side effect.\* Small, fully efficient dosages of decongestants minimize the danger of overstimulation.

DIMETAPP Extentabs contain Dimetane® (parabromdylamine [brompheniramine] maleate) 12 mg., phenylephrine HCl 15 mg., and phenylpropanolamine HCl 15 mg. Dependable Extentabs construction assures relief of symptoms for up to 12 hours with 1 tablet.

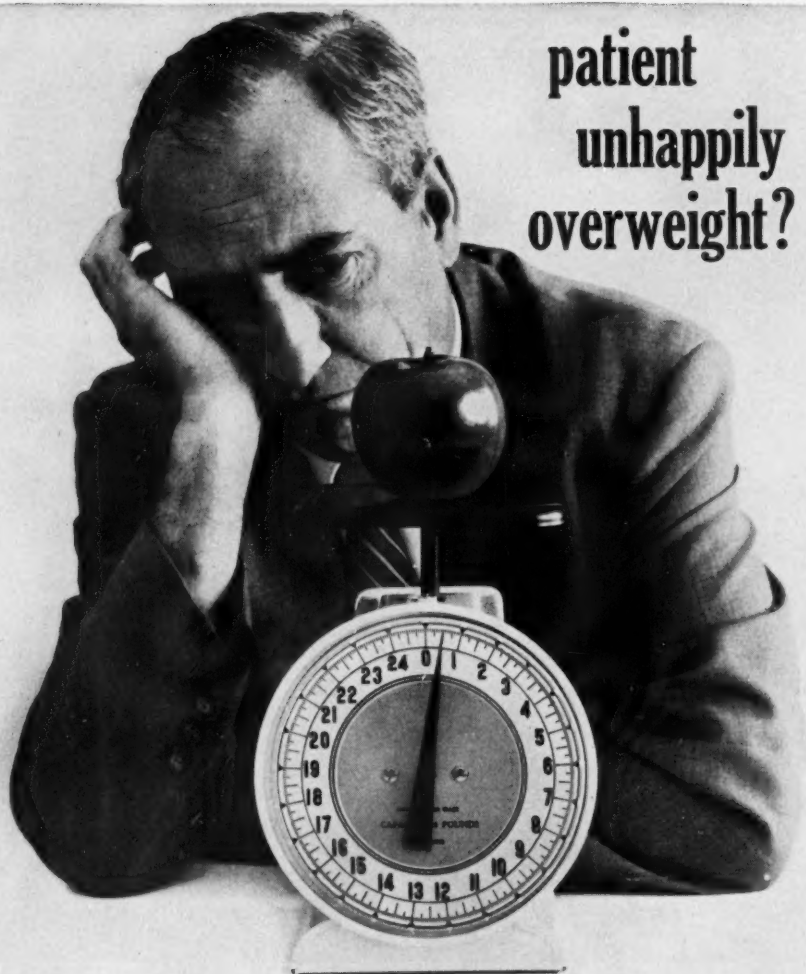
**Dosage:** Adults—1 Extentab q. 8-12 hours. Children over 6—1 Extentab q. 12 hours. Administer with caution to patients with cardiac or peripheral vascular diseases and hypertension, and to those sensitive to antihistamines. See package insert for further details. **Supplied:** bottles of 100 and 500.

\*Full bibliography on Dimetane available on request.

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Ethical Pharmaceuticals of Merit Since 1878



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unhappily  
overweight?



minimize care and eliminate despair with  
**'METHEDRINE'**<sup>®</sup>

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Controls food craving, keeps the reducer happy—In obesity, "our drug of choice has been methedrine . . . because it produces the same central effect with about one-half the dose required with plain amphetamine, because the effect is more prolonged, and because undesirable peripheral effects are significantly minimized or entirely absent."<sup>1</sup> Literature available on request.

Supplied: Tablets 5 mg., scored. Bottles of 100 and 1000.

<sup>1</sup> Douglas, H. S.: West. J. Surg. 59:238 (May) 1951.



BURROUGHS WELLCOME & CO. (U. S. A.) INC., Tuckahoe, New York

Each of the babies pictured on this page was borne by a mother with a *documented* previous history of true habitual abortion, who was treated with DELALUTIN during the pregnancy leading to this birth

## LIVING PROOF OF FETAL SALVAGE WITH DELALUTIN

SQUIBB HYDROXYPROGESTERONE CAPROATE

Improved Progesterational Therapy



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DELALUTIN offers these advantages over other progesterational agents

- long-acting sustained therapy • more effective in producing and maintaining a completely matured secretory endometrium • no androgenic effect • more concentrated solution requiring injection of less vehicle • unusually well-tolerated, even in large doses • fewer injections required • low viscosity makes administration easy

**Supply:**

Vials of 2 and 10 cc., each containing 125 mg. of hydroxyprogesterone caproate in benzyl benzoate and sesame oil.

Also available: DELALUTIN 2X in 5 cc. multiple-dose vials. Each cc. contains 250 mg. hydroxyprogesterone caproate in castor oil, preserved with benzyl alcohol.

Complete information on administration and dosage is supplied in the package insert

**SQUIBB**



*Squibb Quality—The Priceless Ingredient*

\*DELALUTIN® IS A SQUIBB TRADEMARK

IN CONTRACEPTION...



## WHY IS DIFFUSION IMPORTANT?

Because the active ingredients of a spermicidal preparation must diffuse rapidly into the seminal clot and throughout the vaginal canal to be clinically effective. Lanesta Gel offers this *dual* protection. Its four spermicidal agents quickly invade the clot to stop the main body of sperm. It spreads evenly and quickly throughout the vaginal canal—seeks out every wrinkle and fold that may offer concealment to sperm. With this rapid diffusion, your patient receives full benefit of the swift spermicidal action of Lanesta Gel—in minutes—a decisive measure in conception control.

In Lanesta Gel 7-chloro-4-indanol, a new, effective, nonirritating, nonallergenic spermicide, produces immediate immobilization of spermatozoa in dilution

of up to 1:4,000. The addition of 10 per cent NaCl in ionic form greatly accelerates spermicidal action. Ricinoleic acid facilitates rapid inactivation and immobilization of spermatozoa and sodium lauryl sulfate acts as a dispersing agent and spermicidal detergent.

Lanesta Gel with a diaphragm provides one of the most effective means of conception control. However, whether used with or without a diaphragm, the patient and you, doctor, can be certain that Lanesta Gel provides faster spermicidal action—plus essential diffusion and retention of the spermicidal agents in a position where they can act upon the spermatozoa.



# new Lanesta® Gel

Supplied: Lanesta Exquiset® . . . with diaphragm of prescribed size and type; universal introducer; Lanesta Gel, 3 oz. tube, with easy clean applicator, in an attractive purse. Lanesta Gel, 3 oz. tube with applicator; 3 oz. refill tube—available at all pharmacies.

A product  
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Manufactured by Esta Medical Laboratories, Inc., Alliance, Ohio. Distributed by GEORGE A. BREON & CO., New York 18, N. Y.

## BRONCHI AT EASE—DAY AND NIGHT

New Isuprel Compound Elixir, with a pleasant vanilla flavor, keeps the bronchi dilated in patients with asthma and chronic bronchitis. Isuprel Compound Elixir permits easy breathing, prevents bronchospasm, promotes expectoration and reduces wheezing or disturbing allergic or bronchitic cough.

Isuprel Compound Elixir is a balanced expectorant bronchodilator. It provides three bronchodilators, **Isuprel**, **ephedrine** and **theophylline**, with the expectorant **potassium iodide** in one palatable mixture. It also contains **Luminal**® to negate any possible side effects from the adrenergic medication and to provide a mild sedative effect. Isuprel Compound Elixir makes patients more serene by preventing or alleviating symptoms and prolonging relief, day or night.

Isuprel Compound Elixir  
its pleasant taste will be

especially suitable for children, but  
welcomed by patients of any age.

Each tablespoon (15 cc.)  
contains:

Isuprel (brand of isoproterenol) HCl	2.5 mg.
Ephedrine sulfate	12 mg.
Theophylline	45 mg.
Potassium iodide	150 mg.
Luminal (brand of phenobarbital)	6 mg.
Alcohol	15%

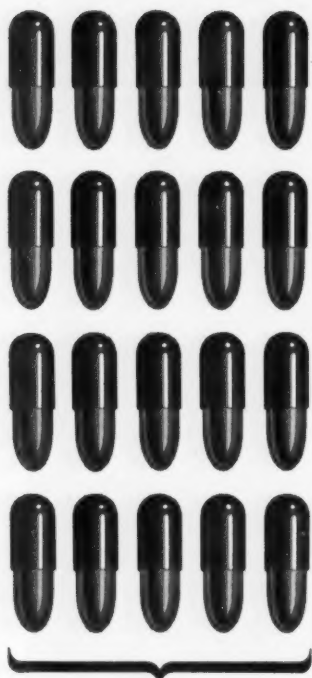
**Dosage:**  
Children—from 1 to 3 teaspoons  
(5 to 15 cc.) three times daily  
as required. Adults—1 or 2  
tablespoons (15 to 30 cc.) three  
or four times daily as required.

*Winthrop* LABORATORIES  
New York 17, N. Y.

## NEW ISUPREL compound ELIXIR

for asthma  
allergic cough  
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Isuprel and Luminal, trademarks reg. U.S. Pat. Off.



■ See  
both blood picture  
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## TRINSICON®

(hematinic concentrate with intrinsic factor, Lilly)

*For a rapid hematological response  
... striking clinical improvement*

Two Pulvules® Trinsicon daily are capable of producing in ten days an Hb and RBC response comparable to that obtained after a transfusion of one pint of whole blood. For potent, complete anemia therapy, prescribe Trinsicon . . . *just 2 a day for all treatable anemias.*

Two Pulvules Trinsicon (daily dose) provide:

Special Liver-Stomach Concentrate, Lilly  
(containing Intrinsic Factor) . . . . 300 mg.

Vitamin B<sub>12</sub> with Intrinsic Factor  
Concentrate, N.F. . . . . 1 N.F. unit (oral)

Cobalamin Concentrate, N.F., equivalent  
to Cobalamin . . . . . 15 mcg.

(The above three ingredients are clinically equivalent to 1½ N.F. units of APA potency.)

Ferrous Sulfate, Anhydrous . . . . . 600 mg.  
(Equal to over 1 Gm. Ferrous Sulfate, U.S.P.)

Ascorbic Acid (Vitamin C) . . . . . 150 mg.

Folic Acid . . . . . 2 mg.

## Foreword on Articles On Medical Writing

J. P. Gray, M.D.

Detroit, Michigan

AMONG physicians and others who read "the medical literature," few will deny that the quality thereof frequently is less than scholarly. This observation is not new. Alan Gregg, in 1943, wrote that "The common level of medical and scientific writing in our professional books and journals already constitutes the most serious internal limitation to medical education and research." The intervening eighteen years have brought less improvement than needed to ease the limitation cited. Actually, communication, in medicine as in other scientific fields, has become increasingly more difficult, if not as a result of, certainly as a concomitant of, intensified research and resultant extension of knowledge in the post-war period.

### American Medical Writers' Association

First organized in 1940, in Rock Island, Illinois, by six editors of medical journals during the annual meeting of the Mississippi Valley Medical Society, the Mississippi Valley Medical Editors' Association was reorganized in 1948. At that time, its scope was widened and its name was changed to the American Medical Writers' Association, the first, and for many years the only, national organization to have the stated objective "... to help maintain and advance high standards in communications concerning medicine and allied sciences..." The Association, under a new constitution adopted in 1951, was incorporated not-for-profit under Illinois law; affiliation with the American Association for the Advancement of Science was accomplished in 1952. AMWA now has more than 1300 members and has its own *Quarterly Bulletin*. Four regional chapters exist: in New York (Metropolitan) organized in 1956; in Philadelphia (Delaware Valley) organized in 1956; in Washington (Mid-Atlantic) organized in 1956; and in Detroit (Michigan) organized in 1957.

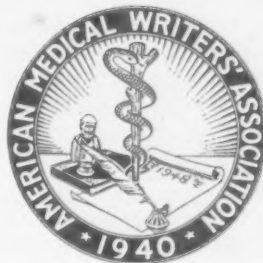
Three significant developments resulting from the Association's activities merit brief description.

### Universities' Curricula in Medical Writing

A basic objective of the AMWA Educational Committee was achieved in 1954 when the Universities of Illinois (Urbana), Missouri (Columbia), and Oklahoma (Norman) announced the establishment of curricula in medical writing in their Schools of Journalism. For the first time, persons interested in opportunities for educational experience leading to baccalaureate degrees, with major work in journalism and minor in medical sciences, were offered

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planned curricula in recognized universities' schools of journalism. These permit such persons to qualify educationally for positions in medical journalism, in medical publishing, and in related fields. Over the years, the influence of these three schools will be a major factor in medical communications.

#### Medical Manuscript Editing Service

The AMWA Medical Manuscript Editing Service, established in 1952 as a non-profit activity, provides competent editorial advice, for a fee, to members of the Association. The service is available also to medical writers not members of the Association, especially to those who have not written for publication before; but fees for them are 50 per cent higher.

#### Visiting Lectureship on Medical Writing

The third basic goal, the Association's hope that a traveling or visiting lectureship might be established, was realized late in 1954. The Visiting Lectureship on Medical Writing, made possible by support from Parke, Davis & Company, was activated in 1955. Under this sponsorship, the lecturer is available, on invitation from deans and other responsible administrative officers, at no expense to them, for lectures on medical writing at schools of medicine and at related institutions in the United States and in Canada. As this Foreword is written (summer of 1960), the lecture, "Communications in Medicine: on Writing," adaptable to various groups, has been presented more than 150 times in five and one-half years (1955-1960). Visits and revisits have been made to thirty-four American and to six Canadian schools of medicine and to related institutions (schools of dentistry, schools of veterinary medicine, hospitals, clinics, government facilities, research institutes, et cetera). The total number of persons addressed exceeds 12,000.

#### Special Issue of The Journal

Late in 1959, the Michigan Chapter of AMWA, with total active membership of less than twenty, undertook the planning of a special issue of THE JOURNAL MSMS and the writing of several papers therefor, on various aspects of medical writing believed appropriate and of possible interest to members of MSMS and to other readers. The Editor, Doctor Haughey, with approval of the MSMS Council and of its Executive Committee, scheduled this special issue for February 1961.

#### Objective

In the AMWA Visiting Lectureship, support for the single lecture approach was found in a statement written by Eugene McCartney, Ph.D., Editor Emeritus, University of Michigan Press: "An awareness of shortcomings must precede all attempts at betterment." From the single lecture, little more could be expected than arousal of interest in the need for improvement in quality of medical writing. Indeed, this, only, is the stated objective of the lecture as basic to all attempts at betterment. No attempt is made in the lecture to teach medical writing. Similarly, the papers appearing in this special issue of THE JOURNAL are not to be thought of as an attempt to present a manual or guide on medical writing: our whole objective lies in arousal of awareness of need for improvement in quality of writing . . . particularly in writing for publication, but, as importantly, in writing clinical records, letters, and other forms . . . writing as a means of communication in medicine. As "an awareness of shortcomings must precede all attempts at betterment," so an aroused awareness of need for improvement in quality of writing is the first step toward improvement.

Readers of THE JOURNAL will find some repetition in the several papers in this special issue. Similarly, differences of opinion will be found on some points. These were expected to obtain, under the circumstances, in which several authors were invited to write on various aspects of medical writing. Authors were asked to keep in mind the ultimate objective of the special issue; but they were not discouraged from making specific suggestions, related to arousal of interest in need for improvement in quality of writing, that might be helpful to medical writers. So, as educators have accepted repetition and difference of opinion, both within reasonable limits, as sound teaching techniques, we hope readers of THE JOURNAL will look upon such attributes in these selected papers as justifiable emphasis of basic principles in good writing.

The Michigan Chapter of AMWA hopes that THE JOURNAL's readers will be as richly rewarded for reading the articles as we have been rewarded in writing them!

*(List of references for this foreword will be found in the amalgamated list of references on medical writing for all papers in this special issue of THE JOURNAL on page 234.)*

# The Roots of Medical Writing

Alfred H. Whittaker, M.D., F.A.C.S.

Detroit, Michigan

Ralph E. Sloan

Dearborn, Michigan

YOUNG men sat on stone benches and listened attentively to the aged teacher who faced them. The classroom was one of many in the eight-story building constructed of clay bricks. Outside, immaculate gardens provided ever-changing beauty as a setting for statuary art. The students were richly garbed and their jewels, exquisitely inscribed, gave evidence that they were of the upper class.

The professor lectured on treatment for gall stones and for bladder troubles, for wounds, for heart trouble and for other ailments with which physicians of the time were concerned. As he spoke, he referred to clay tablets covered with writing—some from that medical school and others borrowed from libraries in other parts of the country.

The school was in the Temple of Baal—in the country of Babylonia, a part of what we know now as Iraq. The time was about 3,000 B.C.—15,000 generations of man before the atom bomb. This period was not the beginning of civilization, but it was the epoch in which reason began to assert its influence upon human destiny. Babylonian culture still contained considerable mysticism and magic, but to that time we can trace the earliest indications of present western civilization. We know that the Babylonian Empire was the culmination of centuries of development but not until then was man able to leave a reasonably comprehensive written record of a highly specialized society and a well-organized and classified body of knowledge.

The Summarians who conquered, then developed Babylonia apparently had controlled the commerce of the world for several thousand years. Their literature and art creations show an advanced state of development that can be traced far into antiquity with increasing difficulty as the manner of communication also becomes more primitive. During centuries of Summarian domination of the western world,

cuneiform writing developed from earlier inscription by pictograph. By the time of Babylonian ascendancy, this method of permanently recording wisdom and knowledge had made possible the perpetual accumulation and sharing of information throughout the civilized world. Clay was plentiful and gained wide use in construction of buildings and in making utensils, even art objects. Stone was not as readily available in that area, and clay tablets were more easily inscribed; undoubtedly contributing factors to the upsurge of writing which resulted in libraries containing thousands of clay tablets and to the duplication of tablets for use in widely separated locations. Impermanence of the material precluded survival of clay structures exposed to the elements but excavations have produced small art objects and many records which depict the life of 5,000 years ago.

Reason had become a major factor in the existence of man during the Babylonian Empire. The earliest tablets of prose, hymns and prayers show a high degree of scholarship and of mental discipline. Schools, attached to all of the temples, were attended by boys, by girls and by adults. Special training colleges were available for surveyors, engineers, astronomers, lawyers, priests and physicians. Their writings indicate clearly that Babylonian doctors were good diagnosticians who methodically and systematically examined their patients and prescribed the remedies indicated in the materia medica and pharmacopeia, precisely as today. Prescription tablets gave the best treatment for each disease, and Babylonian

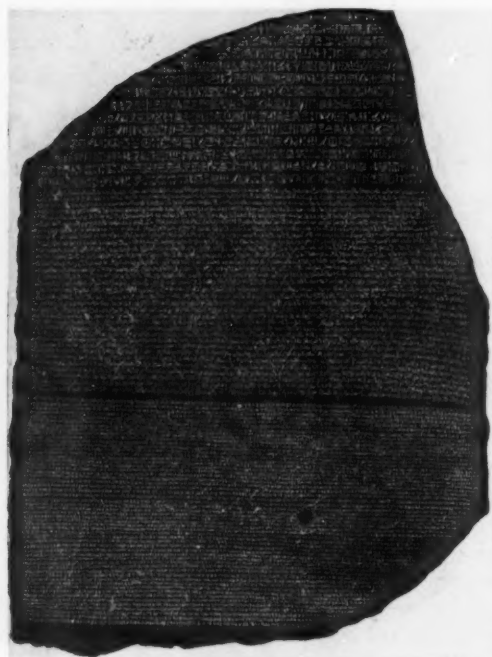
## The Author

ALFRED H. WHITTAKER  
M.D.



Dr. Whittaker is a Fellow of the American Association of the History of Medicine. Mr. Sloan is editorial consultant for medical and scientific publications. Both authors are members of the American Medical Writers' Association.

physicians included homeopathy and allopathy in their principles of practice. As at present, medical men were paid fees for their services, and their work was given status by law. In the Code of Laws



THE ROSETTA STONE

Discovered by soldiers in Napoleon's army at Rosetta in 1799, the stone bears three inscriptions, the uppermost in Egyptian hieroglyphics, the middle in Demotic (a cursive development of hieroglyphics) and the third in Greek, the last being a translation of the two Egyptian texts. With the help of this inscription Thomas Young (1773-1829) and J. F. Champollion (1790-1832) successfully began the process of decipherment of the old Egyptian language.

promulgated about 2100 B.C. by Hammurabi, there are numerous references to the doctor and to the practice of medicine.

A capable medical faculty existed in Egypt fifty centuries ago, and there is no doubt that Egyptian doctors studied medicine and surgery in the medical colleges of Babylonia. The first flexible and easily handled material upon which to write, papyrus, was manufactured from the pith of the papyrus reed. It is native to southern Europe and was cultivated extensively in Egypt and Greece during the centuries before paper replaced it for general use circa 1000 A.D. Papyri survived only when kept dry by covering desert sands, principally in Egypt where papyri

texts dating from 2500 B.C. to 996 A.D. have been discovered. Thousands of papyri taken from Egyptian excavations are written in many languages, including hieroglyphics, ancient scripts, Arabic, Greek and Latin. Most numerous are those in Greek, for that was the official language in Egypt for 1500 years. The Ebers Papyrus and many others shed much light on the work of doctors in Egypt's early history. In the Ebers Papyrus, hieroglyphic references to organs in the human body are copied from corresponding organs of various animals, indicating that Egyptian physicians followed the oriental practice of studying anatomy and practicing surgery with animals rather than men. Egyptian medicine was highly specialized, each doctor concentrating his efforts on only one or two diseases. When Acrototus went there, he recorded finding doctors who specialized in diseases of the stomach, of the eyes, of the intestines, of the brain, of the heart, and of the nerves.

Oriental and Egyptian civilizations were fused in the rapid rise of a semibarbarous race of Aryan stock to The Great Age of Greece which started about six centuries before Christ. The glories of Greece that form the basic heritage of twentieth century western civilization were preserved in marble, in stone and on papyrus. Before modern times, the supremacy of Greek art, architecture, engineering, philosophy, science and literature were unquestioned. Pre-eminently, the influence of Greece in classical antiquity was intellectual and cultural.

With their development of philosophy and of scientific method, the Greeks were able to break away from oriental influence and to pursue knowledge in many directions. The creative forces of Greek intellect were scattered by waves of colonization, and each colony clung tenaciously to its mother language, religion and social customs. Thus, throughout the Mediterranean world, the achievements of Greeks were reported in the Greek language and taught from Greek writings during five centuries before and a dozen centuries after the time of Christ.

Medical historians are well aware that medicine developed not only in Mesopotamia and in Egypt but also in China and in India. They also know that archaic medicine was much the same everywhere. Here, since our major focus is on medical writing, it is sufficient to point out that the earliest Indian and Chinese texts extant are more recent than those of Egypt and of Mesopotamia. Presumably out of reverence for the past, ancient Indian and Chinese systems of medicine are today being practiced on millions of people. In contrast, Babylonian and Egyptian

systems of medicine ran their course centuries before Christ and gave rise to the Greek epoch in medical discovery and practice.

Recent study has emphasized that in ancient Greece, philosophy and science, medicine particularly, were closely related. It is quite clear that those remarkable people combined a passionate interest in details of their earthly environment with indefatigable attempts to explain and to interpret circumstances of life. They were excellent observers with a compelling sense of wholeness, the oneness, of their lives and the urge to encompass wonders of the world about them in intelligible concepts. Early Ionic philosophers tried to determine the primitive element in nature—air, water or whatever it might be. So medical workers from the earliest time, hit upon the idea of proportion as essential to existence. Alcmaeon of Croton was the first Greek to write a medical treatise, to practice dissection and to discover that the brain is the central organ of the sensory-motor systems. He called the equal and cooperative mingling of the separate elements in human nature "Isomnia" and said "Isomnia is health." So the Greeks wrote that health is upset when balance of the several elements is disturbed; and what he called a "monarchy" causes disease. This sense of proportion permeated Greek medical investigation and powerfully influenced all Greek philosophic thinking and writing. This doctrine of the golden mean, as it came to be called, underlies all Aristotle's ethics as well as his writings on natural history. Alcmaeon and his contemporaries, Anaximenes in particular, also developed a doctrine that the human being was a sort of miniature world and that the human microcosm was in direct relationship in composition and functioning with the macrocosm which is the universe itself. So the earliest medical writing reflects a certain awareness of universality. The two concepts of Alcmaeon were enlarged and extended by Empedocles, sometimes called the father of chemistry, who formulated the dogma of the four elements—fire, air, water and earth. This dogma reigned as authority unquestioned until Phlogiston attempted in the seventeenth century to explain human physiology and showed, for example, with the physiology of breathing, the fundamental inadequacy of the four elements dogma.

The history of man's intellectual progress in understanding and in conquering his external and internal environments is a record of reciprocally related accelerations in time and in complexity. In studying the artifacts of primitives and the crude records of pre-history that have survived, major emphasis usually

is placed upon the events *per se* and their impact on physical, social and cultural life. It seems not amiss here, without introducing a "chicken or egg first" controversy, to point out that the civilization established by the Greeks, which is the foundation of our electronic age, was contingent upon communication. In that culture, for the first time, collateral development occurred in many of the arts and the sciences as a result of the ascendancy of reason of accurate observation and of scientific method. These simultaneous developments on all intellectual fronts could not have happened without art forms equal to exacting representation and without a written language adequate for comprehensive recording of fact and of theory, with consequent organization of systematized knowledge, its widespread dissemination, and its perpetuation with rapid increments through education.



MUSEE DU LOUVRE  
Scribe accroupi (The seated scribe)

These factors were particularly relevant to advances in the art and in the science of medicine, in which the tangible and the intangible, the objective and the subjective, the experimental and the theoretical, must be not only recognized but also evaluated and reconciled. Under these conditions, writings were produced which have been preserved under the name of Hippocrates; these mark the first great epoch in the history of medicine as a science and as an art relatively free of superstition and of mysticism.

Some seventy writings which compose the "Hippocratic Corpus" are one of the jungles of early literature in which students have found it exceedingly difficult to disentangle any portions which may have originated with Hippocrates himself. Regardless, in the great collection are found Alcmaeon's elementary principles of balance and relationship of the individual to the universe, fuller development of Empedocles' four elements, and the dual motivating impulses evolved by Greek medicine—love and hate; attraction and repulsion; or, positive and negative. Hippocratic writings also portray a sensing of the significance, almost sanctity, of medical efforts; broad interest with distress, in the drugs and medicaments in common use; insistence upon the importance of natural environment in both the physical and the ethical development of mankind; and, unswerving faith that if the physician could attain calm, a sense of proportion and the confidence of his patient, then the healing power of nature was more effective than any system of diagnosis or treatment evolved by man. Intermittently during succeeding centuries, the Hippocratic principles were restated and reaffirmed; even today, 3300 years later, Hippocrates is revered as the Father of Medicine and his oath continues to be the cornerstone of medical ethics.

Aristotle, perhaps best known of Greek philosophers, was a young boy when Hippocrates died. The fathers of both were physicians but, though they had corresponding philosophies and dedication to human welfare, Aristotle's interests were less restricted to medicine. About forty of some 120 works by Aristotle are in existence and are an encyclopedic index to the knowledge of the fourth century B.C. They encompass logic, natural history, philosophy, psychology, ethics, politics and social issues. Aristotle was the greatest scientist of the early world, probably the first true scientist among those of whom we know. His three great books on animals, the *Historia Animalium*, the *De Partibus* and the *De Generatione*, are crowded with accurate records of observations on structure, on function and on embryology and constitute the greatest contributions to biology before the seventeenth century.

There is a tendency to regard the contributions of Aristotle as the final ones of Greek civilization, but the greatness of Greek influence extended through Alexandrian civilization and through the Byzantine Empire to the fall of Constantinople. One need only recall the manuscripts of Archimedes and of Euclid, who did for science what Aristotle did for logic. Writings of Euclid reigned longer than did those of

any other single teacher, except those in religion, in the world's history. In zoology, Aristotle, indeed, had no close successors, but Theophrastus carried his principles into the field of botany and deeply influenced medical education. Dioscorides, a pharmacologist, became the source of modern botany, and Galen, of modern anatomy and of physiology. Writings of these two were authoritative until the Renaissance.

Turning from Greece to Rome is to turn from a creative and an original civilization to one which, apart from its amazing practical genius, was imitative, and what is imitated is vulgarized. There are exceptions, perhaps, in the poets Lucretius and Virgil; nevertheless, to turn from Aristotle to Pliny is to turn from brilliant original work to rather cheap reproduction. One need only compare the use Aristotle made of animals sent to him by Alexander the Great, during the course of conquests all over Asia, with the slaughter in the arena at Rome of thousands of animals without one Roman publishing a report of study of the beasts.

During a strange interlude in human civilization which began in the fourth century, science became almost non-existent, and fantasy replaced scientific observation. For the next thousand years, literature produced was largely dominated by fable, by heraldry and emblem, and by legend. Though medicine stagnated during those Middle Ages, it had a continuous tradition, perhaps because of its solid groundwork laid by the prolific writing of Hippocrates, of Aristotle and of Galen. In the great thirteenth century, Albertus Magnus, now known as Saint Albert, patron saint of science, among much else produced quite admirable accounts of births. In the fourteenth century, when still there was hardly a single worker in other fields of science, the peasant-surgeon Guy de Chauliac, who became physician to the Pope and who wrote the *Grande Chirurgie* (1368), though he praised Galen, also eulogized the time in life when passion for knowledge creates ability to test the old against experience and to accept or to reject.

During medieval times, there were only tentative ventures in scientific discovery; the history of that period provides fascinating material for sociologic and psychologic study, but only the records of a few more persons of genius—a few poets, a number of artists. Restless forces accumulated during the later Middle Ages to foreshadow rapid transition from one type of civilization to another radically different. As the period drifted into the Renaissance, intellectual and social culture built around the universal

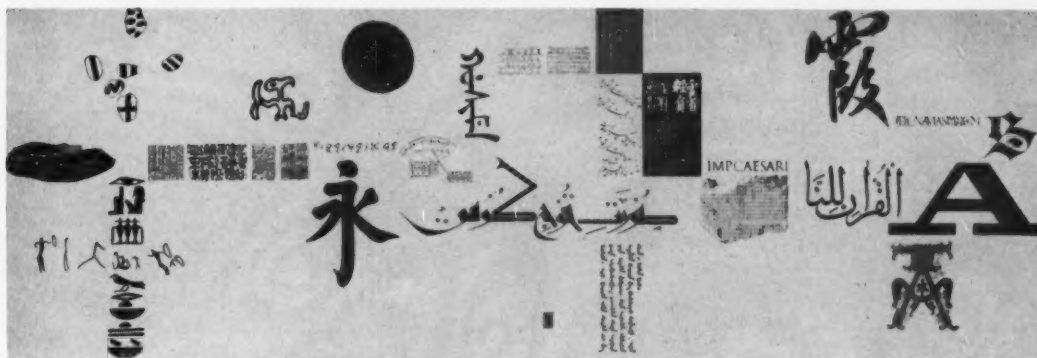


PHOTO-MURAL ON WALL OF ADULT READING ROOM—GROSSE POINTE PUBLIC LIBRARY, GROSSE POINTE, MICHIGAN  
(By Herbert Matter as suggested by Marcel Breuer, French architect)

Matter was born in Switzerland and studied painting with Leger and Le Corbusier in the late Twenties. There he also became interested in photography. Soon he returned to Switzerland and did displays, pamphlets, and posters for the Swiss Tourist Office in Zurich. In 1935, he came to America and did photographic work with Charles Eames in California. He was also Art Director for the magazine, "California Arts and Architecture" and worked as staff photographer for Conde Nast. Today he is staff photographer for Vogue Magazine and is the publicist for Knoll Associates, having designed their catalogue.

The photo-mural which Matter has designed for the Adult Reading Room is a photomontage which consists of enlargements of various examples of ancient scripts: Greek, Roman, Hebrew, Arabic, Sanskrit, Egyptian, Chinese, et cetera. Each example of script is an ancient saying or proverb. Not only the various examples of lettering in neutral tones but also the arrangement of these samples against a white background is striking in its decorative effect. And what could be more appropriate for the decoration of a library than early examples of communication by the written word.

church and around feudalism began to disintegrate. Material prosperity from rapid growth of commerce and of industry created a wealthy leisured society of city dwellers who had time and opportunity for pursuit of secular culture. Class lines were erased, and the individual was allowed freedom to express his personality. With replacement of guild organization by the capitalistic system, economic power passed from the company to the individual. Filled with enthusiasm and curiosity, men strove to develop all their facilities and to exercise all their talents. Avid for immortal fame, they broke with tradition, and interest in Greek and in Roman antiquity was revived to provide substance for critical inspection and re-appraisal.

Until the Renaissance, physical as well as intellectual restrictions hampered both accumulation and distribution of knowledge. Writing, more precisely paleography, originated with primitive man's efforts to depict graphically the objects around him. Art forms continued to be basic tools of communication until standardization of pictographs produced the ideogram, followed by phonetic writing, first in syllables, then in alphabetic characters. Cuneiform, throughout its long history of use, never developed

an alphabet. In early prehistory, the individual with a desire to communicate must have been able also to execute the necessary graphic forms. By the time of Babylonian civilization, scribes were plying the art of calligraphy in putting on stone, on marble, on clay tablets and on papyrus the thoughts of others and in making copies of existing writings. Until the end of the Middle Ages, unification of religion, philosophy and government enfolded all intellectual activities so that we are indebted to scribes of ancient times, to those of Egypt, of Greece and of Rome, and to medieval monks for the survival of much of our historical knowledge.

Art not only was the basis for the earliest communication but also continued to amplify and to extend the effectiveness of writing when it did not excell. Artists of the early Renaissance were carving and drawing readily identifiable plants and animals, but in herbals and in bestiaries of that time the illustrations were copies of purely imaginary pictures, and it is hopeless to try to identify them from descriptions by the authors.

In ancient times, schools were naturally associated with temples which were centers of all teaching. Institutions for advanced study existed during the

Greek and the Roman Empires, but the university we know today originated in the Middle Ages as another facet of the entirely new civilization developing in the western world. Among many, economic wealth and separation of church and state were prime factors involved in the favorable climate for development of academic centers in response to a revival of interest in law, in medicine and in philosophy. One of the earliest was the medical school at Salerno, established in the eleventh century. Universities were established as outgrowths of monastic schools or were developed from informal gatherings of students around great teachers. It was logical that the general organization of schools follow that of the guilds of that time; thus, the student first was an apprentice, or *baccalaureus*, then a master. A further period of study was required to become a doctor in more advanced studies of theology, of law and of medicine. The importance of education was being recognized and schools were fostered by privileges from a locality or from the state consisting of tax or of military service exemptions. Charters also were granted by the Pope or by the Emperor. Control of granting degrees was held by the masters' guild until in the thirteenth century when the church asserted its right to control education by requiring consent of the chancellor. Of seventy-nine universities established by 1500, a number still survive.

The return to intellectual pursuits, the development of education, and progress in arts and sciences of the Renaissance had repercussions. Legal theory from the revived study of Roman law favored state churches and absolute instead of communal ownership of property. The Protestant Reformation in the sixteenth century ended the unity of the medieval church in the West. With this social revolt, which was the culmination of many factors operating through hundreds of years, religion was recognized as an inward quality which cannot be forced, and enlightenment was substituted for constraint. In education, scholasticism characteristic of medieval philosophy dominated universities even after the Renaissance brought new studies and new methods. The Reformation adversely affected attendance and resources at first but later stimulated creation of many new universities. Even then, universities tended to follow traditional routine and looked askance at new subjects. During the low ebb of higher education in the seventeenth and eighteenth centuries, new subjects began to be cultivated by independent academies and by learned societies. The first modern universities based on academic freedom and dedicated

to new studies and research (Halle, 1694 and Göttingen, 1737) precipitated modernization of institutions of higher learning throughout the world, including the United States where the work of English colleges was carried on with increasing vigor after the founding of Harvard College in 1636.

Endowed with the ability to think, to reason, man could not escape the primary urge to improve his existence, or recognition that understanding is requisite to improvement. Oversimplified, these needs are for understanding supernatural and natural phenomena. Spiritual explanations have been sought in superstition, in idolatry, in mysticism, in philosophy and in religion. In early history, all scientific exploration of nature was motivated by interest in the welfare of the individual human being. As late as the fifteenth century, universities had faculties only of theology, of the arts, of law and of medicine. Thus, the tradition of the doctor is all-inclusive, and medicine was the incubator for all the biologic sciences and, later, of new sciences formed by combinations of physical and of biologic sciences. The implications are clear. Medicine not only was required to make discoveries in all early science and to develop improved methods for further exploration but was forced also to devise whole new systems of terminology, to organize vast amounts of new knowledge, to work with artists to obtain adequate illustrations, to publish comprehensive and detailed manuscripts, and to provide for the education of following generations.

Intellectual prowess and physical achievement always go hand in hand and in the panorama of history it is seldom of major importance to know which was cause and which was effect. Here, there is little relevance in whether intellectual and cultural progress stimulated refined methods and materials of communication, or the reverse. It is enough that as written language evolved from pictograph through cuneiform and syllabic forms to alphabetic symbols, stones and clay tablets gave way to papyrus, which was replaced by paper. We can be sure that more than coincidence was involved: in the introduction of papermaking to Spain by the Arabs in the eleventh century and the spread of the art of papermaking throughout Europe in the twelfth and thirteenth centuries; in founding universities during the same centuries; in the revived interest in learning of the Renaissance, in the middle of which Gutenberg first printed from movable type (1445); and, in the vast expansion of universities and learned societies from the Reformation to the present.

In a manuscript which employs less than one word

per year of history covered, it obviously is impossible to do justice to any single factor which had significant impact on the course of man's conquest of his environment, or even to place these developments firmly in the proper perspective in relation to each other. History of milleniums is not a record of concerted, organized progress on all fronts; rather, it is the implacable, pulsating advance of floodwaters against an obstruction, with attack and recoil in search of weakness and failing this, accumulation until the deterrent is overcome by engulfment. The vastly accelerated tempo of our twentieth century rate of discovery is sustaining this fundamental truth that overall progress can proceed no further and no faster than its most limited or slowest component—the weakest link. In the last half-century, science has given man unquestioned domination of this world except for man himself. Scientific method has been carried to a high degree of refinement and results of collateral science and technology have reached an advanced state of integrated organization. Assembled knowledge has been applied in constantly increasing complexity until it has made reality of the fumbings of early alchemists and the speculative dreams of early astronomers. No one could reject the concept of communication as basic to recording, transmittal, reconciliation, organization and perpetuation of knowledge which has made all progress possible.

Today, the synchronous development of science on myriad fronts has become almost simultaneous. With victory over environment on this planet largely achieved, in principle if not yet in fact, men of science have extended their vision to probe for knowledge of the universe in which our earth is an

insignificant pinhead. In this fantastically huge scheme of all nature, man seeks knowledge of all creation, including life itself. Time may reveal that in relation to the cosmos, twentieth century science still is primitive. It is certain that the snowballing rate of erosion on the mysteries of life, however facilitated by ingenious robots and electronic computers, will continue to demand increasing intellectual effectiveness also in individual and in collective application of reason. The maximum mental capabilities of any single human being, to assimilate, to organize and to evaluate, were exceeded centuries ago by the then available knowledge. The written word became the medium of intellectual intercourse and the storehouse of fact and of thought. As scientific writings continue to multiply in complexity as well as in volume, expanding requirements of research must be paralleled by corresponding criteria for publication of results. Early in the attack on space, it became clear that ultimate success is contingent upon direct on-the-spot observation by human beings, even beyond our minuscule solar system. Inanimate conquest of stars beyond the range of the 250-foot radio telescope is a tenable concept now; transport of human intelligence in a form capable of making observations and returning information a hundred or thousands of generations later is still incomprehensible. Yet this is to be the task of medical and of other biological sciences. As the tiny breach already made in this great wall is widened, medical writing, too, must always become more exacting and more discriminatory, with quantity and diversity counterbalanced by greater specificity and completeness, and with clarity through use of precise, meaningful words.

### ***New Tuberculosis-Like Disease***

The Veterans Administration, in 1960, registered 710 cases of a tuberculosis-like disease which has come to the attention of physicians in the United States during recent years.

As yet, the disease has no name more specific than "infections due to unclassified mycobacteria." The infections closely simulate tuberculosis and usually affect the lungs.

Since the prevalence of the disease in this country

is unknown, the Veterans Administration undertook the task of compiling a case register from the agency's hospitals and clinics on a nationwide basis about a year ago.

So far, California has reported the highest number of cases—ninety-five. Michigan reported thirteen.

The register will be used by the Veterans Administration for evaluating treatment of these patients and developing new research approaches to the disease.

# Ethics in Medical Writing

C. Howard Ross, M.D.  
Ann Arbor, Michigan

THE GREEKS had a word for it—*ETHIKA*—indicating that custom had taken on character. Thus an ideal permeated hand-me-down usage.

In ancient Sanskrit, there bobs up the term—*Svadhā*—meaning to set one's self. Hence, by one's own doing, he could improve upon an expected performance in the routines of life and encompass others into his inner richness.

As a contrast, Judge Medina warns us, "It is so easy to think of oneself and let the rest of the world go hang."

Specifically, we date our basic ethics upon the moral works of Aristotle, the fact-finder and amateur evolutionist. Here the nature of the *summum bonum*, or highest good, is delineated. However, there was no sudden or explosive derring-do gush into the historical field of ethics. Earlier fragments are found, where the contemplative author pauses to reflect upon precepts of conduct.

Plato healed the gap between Socrates and Aristotle straddling a metaphysical "asses' bridge." He introduced mystical and esthetic segments to philosophy and moved his brain from the "supermarket to the college hall."

Aristotle founded literary criticism, and as philosopher, moralist and pedagogue he expended much energy upon his student, who later became Alexander the Great.

## Goodness

Aristotle's Ethics contain a world of thought, influencing his immediate successors more lightly than his remote lucubrating disciples. However, as the centuries passed, controversies ebbed and flowed

about the notion of *Goodness*. That seemed to be our first ethic, and bitterness gradually subsided when its halo appeared. Whether a man lived a life, dug a garden, practiced a profession, gave a speech or wrote a book, one could ask, "Was it good? Was he good? Was there well-being as the ultimate goal?" If the current philosophical hero could not perform a role in his own right, could he quote a superior on the subject of quality? Thus each generation enacted and emphasized this ethic of goodness.

## Wisdom

"One could not perform as an impassive sage." Soon philosophy recognized *Wisdom* as an entity of ethics. At least two classes of higher citizens loomed above the tantalizing horizon, those that were "good"—and those that were "good and wise." A tiny hamlet in its isolation did not possess sufficient exposure to the great world beyond to cultivate many wise ones. However, in the cities and cultural centers, there arose the cult of wisdom, and Ethics chalked up number two on the score.

## Knowledge

As schools developed, and teachers disseminated thought-provoking principles, *Knowledge* entered as the third great ethic. If one were going to open his mouth to teach, or to take a fervent breath to preach, or to screw his courage to the written page, it was well that he possessed some organized idea of what he was expounding. If wisdom were the only ethic, then the lack of wisdom yielded evil. But if wisdom were a broad ethic, then it could encompass the spectrum of philosophy and delineate between good and evil, with knowledge tilting the balance.

## Hippocrates

Man or men or partial myth or combination of all, Hippocrates was a contemporary of Plato and a precursor of Aristotle. He has served as "Father of Medicine" these many centuries. Much that he wrote,

Presented before the Student-Faculty Assembly, Wayne State University College of Medicine, November 6, 1959, and before the Senior Medical Class, University of Michigan, November 25, 1959.



The Author

C. HOWARD ROSS  
M.D.

or his students concocted, plus samples of fairly ethical writings of unknowns—were “dumped” into the Hippocratic Collection, only to be deleted or added to as the centuries passed. To many medical writers, the controversial figure of Hippocrates is a symbol of surety and truth, since he gave us an oath of guild ethics and eliminated the responsibility of the physician in employing the medical incantation.

Thus he became, by tradition, a constant element above the thunder of scholastic warfare. According to Celsus, he was the first one “to separate medicine from philosophy.” Superstition was eliminated by Hippocrates from the medical literature of his times.

Hippocrates regarded his fellow practitioners as his brothers and looked upon a medical apprentice as his son. In his writings, he carefully attempts to delineate symptoms and findings before hazarding a diagnosis. On many occasions he hints a prophesy of our most modern ethic, “good medical care.”

Hippocrates and his group amaze me at the clarity of their style. While brevity is preached—with so much to say—it is not practiced, but obscurity and confusion are far from the aims demonstrated.

### The Spirit

When the Universal Church spread its principle of *Service to Others* throughout Europe and the Middle East, the confirmation of an old ethic became a new ideal. I hold no ethical grudge against any religion. Probably my limitations do not encompass their mechanics, like Paré; but I rejoice in the “Spirit” of the Judaeo-Christian-Islamic Faiths and Oriental philosophies. This spirit has crept into our modern medical writings and pervades our aims. An agnostic physician may not know where to place his ecclesiastical vote, but the spirit of service to others, infiltrating his writings and acts—indoctrinates him within the confines of ethics and places a “well-done” upon his contributions.

### Definition

So far, then, I would like to define *Ethics* as the performance of *Morality*, and morality to me is the practice of the *Golden Rule*, with “a modern shot of vitamins.” There is a positivity to this definition. You will recall Paré’s ethics as a series of negations:

“I will not return to my mother’s womb.”

“I will not fight in battle.”

“I will never desert the king.”

“I will not accept the mechanics of the church, but I will accept its Spirit.”

There you have it. The negations ended, but the positive Spirit began to assert itself.

### Dicta

Galen’s ethics of the second century, A.D., were so thunderous that they lasted for thirteen and a half centuries. He was a perfectionist and a great medical egoist. He actually felt that professional and lay communities required no other authority than himself. This domineering technique is ethically distasteful today.

The man that gave Galen an historical kick in the pants was Phillipus Aurelius Theophrastus Bombastus von Hohenheim, known to us as Paracelsus. He shouted backwards at Galen and the great Iranian physician of the eleventh century, Avicenna, “I shall not follow you. Me—me—you will follow!” This was a sort of retroactive reversal of ethics.

He burned the Latin works of Galen in the public square and then attempted to create scientific and ethical terms in the Germanic medium.

In addressing the student-faculty assembly at the University of Basel, Dr. von Hohenheim aimed his remarks at his confrères disdainfully, “There is more brain power in my beard than in all of you.”

One concludes that he did not go over well. He confused “medical exposure” with “medical honors.” From safe observation, he could concoct a theory of “thin fantasy.”

Dicta of gross or offensive nature do not belong in ethical medical writing.

An author should not “wear blinders” against new scientific adventure.

### The Place of the Theory

William Harvey pronounced his theory of the true circle of the blood in 1616. He assumed the existence of capillaries without ever having experienced their retinal image. In fact, his theory was in advance of Galileo’s microscope by eight years. The ethical publication of “The Circulation of the Blood” did not occur until 1628. That year was the birth date of Malpighi, who later witnessed the lowly corpuscles whizzing in the capillary beds of the obedient frog’s lung, proving Harvey’s dissertation.

Theories, based on observation, certainly have a place in ethical medical writing. This may also be true of theories based on all facts but one. Here a bridge is created, linking the “known of today to the unknown of tomorrow.” Later generations, however, may have to be born, then rise and shine, to prove the intent and to confirm the ethics.

Harvey taught us that we must not be distant and aloof from our chosen subject.

### Experimentation and Reporting

The recording of scientific experimentation certainly places itself high in the standards of ethical medical writing. I am thinking fondly of the Michigan backwoods gastro-physiologist — Beaumont. He "shook the world by its gastric juice" in 1825, when he first presented the digestive sequences of Alexis St. Martin's fistulous stomach.

Many observers before Beaumont and thousands after him have entered into medical writing. Here Ochsner warns us against statistics taking on a rosier hue than warranted.

Somewhere, a picture must become clear, and a hesitant conclusion awaits being drawn. If neither occurs, ethics disappear because the spirit has died.

Modern tabulations that are so profuse that they become obscure, dodge the dictates of ethics. If the writer blooms into a lecturer, and the fine print on the devilish slide cannot be read by an intelligent audience, he has discarded his pedagogy and trampled upon his ethics.

When the written word is translated into the hoped-for audible word, but alas is not heard or understood through the limitation of expression or by microphone failure, the medical spirit has withered. Ethics have faltered; dullness and monotony have taken hold.

It is ethically important that custodians of a lecture hall be as alert in presenting a broadcast as an editor is in "slicking up" an article for publication in a medical journal. When the speaker fails to communicate in the language of his audience, he is ethically invited to attend a class in public speaking and to become "hep" to the demands of medical communication. A lecturer who pounds and shouts at his manuscript does not improve it, but fails to recognize his audience and thus misses the ethical boat entirely.

A speaker expecting vibrant attention from his listeners, is invited to "return the compliment in advance."

### Plagiarism

In at least five sources, I have observed a repeated thought that runs something like this, "Originality is subconscious plagiarism."

The Latin word *plagium* refers to kidnapping. I would like to dwell a thoughtful moment upon the subject of kidnapping ideas, expressions, entire

articles—without regard to the dainties of recognition.

Since we are what our ancestors, our environment and the inner self have created, it becomes increasingly difficult to stand alone as a substantial Niagara of power. Emerson hinted that no pure originality exists. Nonetheless, quotation marks are not architecturally difficult to manipulate, and the jealous writer may become the generous and well-read producer by their employment.

Acknowledgment, graciously done, to source material, to inspirations, and to techniques, serves as an ethical instrument in medical writing. It not only places the author in happy perspective to the reader and to the original creator, but "reflects his experience upon the mirror of others."

When an author quotes himself from a former observation, no one will accuse him of self-plagiarism. He at least should possess a corner on his market slightly superior to that of the reader, who is seeking scientific adventure by scanning the first page.

### Copyright

Let us consider a "loan of words" that has reached several lines from an article protected by copyright. It is now high time that correspondence be initiated with the writer, out of courtesy, and with the publisher, out of legality, to secure written permission to quote. I realize that scientific writing is done for the general welfare of the human race, and a judge plus a jury of peers may think twice before naming a budding genius as culprit. Let us not be so blissfully hopeful that we become regretful, however.

If we quote from a distinguished source, let us not garble the message. What is within the "lifted word" should shine in its pristine purity. Thus, rough scratch notes made by a slam-bang researcher in his off moments at the library, cannot be blown up later by his own bicycle pump and then called original source material.

These same rules of courtesy and copyright apply to charts, to graphs, to photographs and to technical illustrations that one may borrow to complete or to emphasize an article.

The patient himself must be consulted if his identifying photograph is to accompany a contribution, whether its introduction is original or secondary.

A confession of original "quip or quote" is like returning a borrowed lawn mower to the proper though anxious owner. Medical writing ascends to a level of dedicated pedagogy, but it must not in its sublimity become the rumbling cause of a snarl.

### Summary

In commenting on "Ethics in Medical Writing," I have leaned heavily upon the crutch of the past.

Word sources from ancient Greek, Latin, and Sanskrit have been shaken out of their comfortable niches and reactivated.

Tribute is paid to the philosophies of Socrates, Plato, and Aristotle. Their historical disagreements have yielded to us workable truths.

Each individual ethic as it developed in history is enshrined within our modern medical writings. I have developed and make my bow to *Goodness, Wisdom, Knowledge, Hippocratic Truth, The Spirit, Service, Morality, The Theory, Experimentation, Reporting* and, lastly, *Good Medical Care*.

I have urged that dicta of gross or offensive nature

be avoided in medical writing. The author must be in ethical charge of his creative forces.

When the written word becomes audible, the medical speaker is ethically bound not only to be *heard* but *understood* by his audience. Shouting at a manuscript does not improve it. I make my plea that the assembled physicians rank equally with the manuscript and be given vibrant attention by direct address.

Plagiarism, the rules of recognition and copyright have been analyzed and discussed.

Medical writing ascends to the level of dedicated pedagogy.

(List of references for this paper will be found in the amalgamated list of references on medical writing for all papers in this special issue of THE JOURNAL on page 234.)

## Quantitative Cytologic Study of Anhydrous Mass in Regenerating Liver

In the present study, we measured anhydrous mass of liver cells following partial hepatectomy. Hepatectomized rats were sacrificed daily for six days and later intervals. Liver was perfused with cold physiological saline containing versene and suspensions of liver cells made, mounted in glycerol and examined with a Cooke-Dyson interferometer microscope. Cytoplasmic mass was calculated by formula:  $M = \Delta_m A / \chi$ , where  $M$  is total anhydrous mass,  $\Delta_m$  optical path difference,  $A$  area and  $\chi$  proportionality factor. Our calculated  $\chi$  was  $0.0663 \text{ cm}^3 \text{ gm}^{-1}$  for fixed glycerol mounted liver cells. We found mean normal value of anhydrous mass in single liver cells to be  $14.16 \times 10^{-10} \text{ gm}$ . On first and second day after hepatectomy, there was a sharp increase in mass to 16.88 and

16.46 with rapid drop on third and fourth day to 13.72 and 11.49, followed by gradual increase in mass. Decrease in mass after second day corresponds in time to peak of mitosis and cell division. Sham operated animals on first and fourth day gave liver cell mass of 14.20 and 14.23 which is same as normal. As far as we know, this is the first time cytoplasmic mass of liver cells has been measured in normal and pathologic conditions. The significance of findings in relation to liver pathology will be discussed.—BJARNE PEARSON and FRED GROSE, Wayne State University and Detroit Institute of Cancer Research. Paper presented before Detroit Physiological Society, December 15, 1960.

# Suggestions for the Author of a Medical Paper

S. E. Gould, M.D.

Eloise, Michigan

**M**OST physicians of repute become known by virtue of their writings. In the interest of improving the quality of medical writing, the following suggestions are offered for consideration of the author of a medical paper.

## Subject

The paper should have some special interest for the reader, as in reporting of a new, unusual, or significant observation. It should be documented by presentation of pertinent data and illustrative material, and by references to cited authors. The writing should be concise and easily understandable. After the author has outlined his project, he must consult the pertinent literature to learn what is already known concerning the subject. The author should report his data and opinions in such a manner that the reader is free to judge the merits of the observations, interpretations and conclusions.

## Style

The manuscript should conform to the styling of the journal to which the author submits his paper, including: format; listing of names of authors, their degrees and academic or hospital positions, department from which the paper is submitted, and source of financial support or sponsorship of the work; length of manuscript; use, typing and position of headings and subheadings; form of summary; arrangement and amount of tabular and illustrative material; use of footnotes and acknowledgments; and

details of listing of references. The periodical should be consulted for its stated editorial policy and requirements.

## Title

In general, the title should not exceed eleven words. If necessary, a subtitle may be used. The title (and subtitle) should indicate the nature of the report and subjects to be indexed. Running headline (condensed title for top of right-hand printed pages) should be furnished, consisting of not over thirty-five letters, each space between words being counted as a letter.

## Typing

The manuscript should be neatly typed, double-spaced on white bond paper, measuring 11 by 8½ inches, of good but not extra heavy or expensive quality. All material should be double-spaced, including title sheet, quoted material, tables, legends, and references. The left-hand margin should be at least 1½ inches wide, others at least 1 inch wide. Use of footnotes should be avoided; if footnotes are essential and permitted, these should be arranged numerically and typed double-spaced on a separate sheet. A carbon copy of the final draft should be retained by the author for future reference and for checking against galley proof. A clean, fresh, original copy should be submitted to the editor. The pages should be consecutively numbered at the center of the top and not fastened with clips or staples. The manuscript should show evidence of care in use of English, spelling and punctuation, and in organization of material presented.

## Quotations

One should not copy another author's quotation or interpretation of work of a third author, but should consult the original source to check the accuracy of the quotation or interpretation.

Dr. Gould is Pathologist, Wayne County General Hospital, Eloise, Michigan, Professor of Pathology, Wayne State University College of Medicine, Detroit, and formerly Editor-in-chief of the *American Journal of Clinical Pathology*.



*The Author*

S. E. GOULD  
M.D.

### Illustrations

Illustrations are generally of two types: pen-and-ink drawings, reproduced by the line engraving process, and photographs of any material containing shading, reproduced by the halftone process. Every figure should be identified by writing lightly in pencil or by pasting a label on the reverse side, giving the name of the author, figure number, abbreviated legend, magnification (in the case of a photograph or photomicrograph), and indicating the top of the figure. One should not attach a paper clip to illustrative material or write heavily on the reverse side, for it might damage the face of the illustration. All drawings should be made with India ink, preferably on tracing vellum, white drawing paper, or white drawing board of good quality. If coordinated paper is used, this should be blue-lined so that cross-sectioned lines will not reproduce in the printed figure. Lettering should be of professional quality and large enough to be read easily after reduction. In general, legends should not be lettered or included in the body of the chart but should be typewritten. Charts should be attractive in appearance and easy to understand.

Photographs, photomicrographs and other illustrative material such as x-ray films should be easily understood, pertinent, instructive, and of excellent technical quality. They should show detail and have good contrast with the backgrounds. Photographs should be glossy and unmounted. A recommended size of photographs is 7 by 5 inches. Illustrations should be larger than the size desired in the printed article. Legends should be fully explanatory and typed double-spaced on a separate sheet of paper. A photograph in which an individual can be identified requires the permission of that person for publication; if permission is not obtained, the eyes should be covered by a circular or rectangular piece of white paper.

### References

As a rule, the care with which the references have been prepared is a good indication of the quality of the manuscript. Misspelling of an author's name or incorrect designation of his initials constitutes a serious error. In reviewing the literature, sources of references in addition to *Quarterly Cumulative Index Medicus* and *Current List of Medical Literature* should be consulted. These may include the *Index Catalogue of the Library of the Surgeon General's Office*, *Biological Abstracts*, *Excerpta Medica*, cumulative indexes such as those published in *Surgery*, *Gynecology and Obstetrics*, year books, and recent

volumes of periodicals (in English and foreign languages) devoted to the special division of medicine that embraces the subject of the paper. No reference should be listed unless it is cited in the paper.

In preparing the list of references, consult original sources for exact spelling of names, titles, periodicals, volume, pages, year. Abbreviations of journals should generally correspond to usage in *Quarterly Cumulative Index Medicus*. In listing references to a book, give the name, title, edition number, city of publication, name of publisher, year, page or pages cited and total number of pages of book. In listing reference to a paper published in a foreign language, give full foreign title if this can be written in English characters, followed by English translation in parentheses.

### Copyright Regulations

In quoting verbatim, copyright regulations should be observed. For most material, it is permissible to quote fifty to 100 words or two or three sentences without specific authorization. Permission to reproduce copyrighted material, including figures and tables, must be obtained from the copyright owner. As a matter of courtesy, permission should also be obtained from the author and the editor of the publication. Acknowledgment should be made in the printed manuscript to the author and the copyright owner that permission has been granted for reproduction of the material borrowed.

### Some Specific Usages

#### Measurements

Term to be Avoided	Correct or Preferred Term
cc.	ml. (1 ml.=1.000027 cc.)
6 3/4 cm. or 2.5 inches	6.25 cm. or 2 1/2 in.
size of a lemon	(Give measurements in cm.)
urea in blood, 15 mg. per cent	15 mg. urea per 100 ml. blood

#### Word or Term

Term to be Avoided	Correct or Preferred Term
2,697 individuals	2,697 persons (or patients)
X-rays revealed no pathology.	X-ray films revealed no evidence of disease.
Patient was esophagoscoped (electrocardiographed, x-rayed).	Patient had an esophagoscopy (or other) examination.
No malignancy was present.	No evidence of malignancy (or no malignant tumor)...
He had no temperature.	He had no fever.
this case of cancer	this patient with cancer
right neck (chest, abdomen)	right side of neck (chest, abdomen)
to biopsy the liver	to take tissue from the liver for biopsy

# SUGGESTIONS FOR THE AUTHOR—GOULD

## Word or Term (continued)

Term to be Avoided	Correct or Preferred Term
The patient was biopsied.	Tissue was taken for biopsy.
nouns as adjectives: Tumor Registry Committee Progress Report	Report of Progress of Committee for Registry of Tumors
adjectives as nouns: diabetic, syphilitic, humans, thyroid, prostate	patient with diabetes (or syphilis), human beings, thyroid gland, prostate gland
Babinski	Babinski's sign (or reflex)
a 6 x 7 cm. mass	a mass, 6 by 7 cm.
the glucose content in the blood	the concentration of glucose in the blood
brownish red	brown-red
This data is . . .	These data are . . .
The patient was considered to have . . .	It was thought (or believed) that the patient had . . .
The condition was considered to be . . .	The condition was regarded as (or believed to be)
lymph gland	lymph node
this female	woman (or girl)
pathological, physiological	pathologic, physiologic
This condition was due to . . .	. . . caused by, or the result of
due to this condition	owing to this condition
cerebrovascular accident	Specify whether cerebral thrombosis, hemorrhage or embolism.
Patient (or lesion) was tubercular	tuberculous
too frequent use of relative pronoun which	that. (That is defining or restrictive, which is non-defining.)
too frequent use of marked	severe, great, much
too frequent use of this as pronoun	Specify noun.
The lesion shows . . .	. . . is, consists of, has, is characterized by
there was	(Use only occasionally.)
decubitus ulcer	decubital ulcer
The hematocrit was 44 per cent.	. . . hematocrit reading . . . (Hematocrit is an instrument.)
to differentiate these tumors	to distinguish . . .
these subjects	patients or persons
excessive use of very	delete very
auricle	atrium
papanized, trypsinized cells	papain-treated, trypsin-treated
because of the fact that	because

## Spelling

Term to be Avoided	Correct or Preferred Term
10 ml. (at beginning of sentence)	Ten milliliters . . .
Bence-Jones protein	Bence Jones protein
Wasserman test	Wassermann test
Hoffman reflex	Hoffmann's sign (or reflex)
epididymes (as plural of epididymis)	epididymides
Ascheim-Zondek	Aschheim-Zondek
gastro-intestinal	gastrointestinal
leucocyte	leukocyte
Endamoeba Histolytica	Endamoeba histolytica (italics)
8 weeks incubation	8 weeks' incubation

## General Comments

It is assumed that the work to be reported is accurate and will stand the test of checking by others. If this is not true, it is a mistake to submit the work for publication. The author should be as meticulous in the preparation of his manuscript as it is assumed he has been in the conduct of the clinical or laboratory work that he wishes to report.

A paper should be revised repeatedly before the author can regard it as suitable for publication. The transcript should be written in as few words as are consistent with good usage. With each condensation of the essential data and interpretation, the paper will usually gain in readability and effectiveness. Before submitting the paper for publication, it is suggested that the author send it to one or more experts in the field for their frank comments and criticisms. He may also wish to ask a qualified person to check the rhetoric. If there is any secret to good medical writing, it lies in repeated review and reworking of the paper.

When the final draft has been completed, the author should be able to answer the following questions affirmatively: Does my paper contain something new or significant? Is my presentation interesting, easily understood and well written? Is this a creditable report? Do I believe that the editor would be eager to publish this paper? The author should remember that the editor occupies a position of trust in presenting to his readers the best material available to him. The author must, therefore, solicit the interest of the editor and strive to satisfy his requirements.

To be jealous of the woman one loves is to give evidence of a strange lack of reasoning power. Either we are loved, or we are not; and, in either case, jealousy is a passion which is of no use to mankind; it cannot be accounted for any more than fear; it may be that jealousy is fear in love. A jealous man does not doubt his wife, he doubts himself. —"The Physiology of Marriage" by HONORE DE BALZAC.

# The Scientific Paper

S. Howard Bartley  
East Lansing, Michigan

AN ARTICLE appearing in a scientific journal should differ considerably from one appearing in other journals or magazines. Although this is generally taken for granted, the characteristics of a proper science article are not always clearly understood.

The characteristics to be discussed in the present article will have as much or more to do with the scientific paper's content as its format. Formats vary considerably from journal to journal, and nothing rigid can be said about them. That the paper's intellectual content rather than format is of prime importance is greatly emphasized in a lengthy paper written a few years ago by Hans Selye, entitled, "How Not to Write a Medical Paper." The paper was almost entirely devoted to the discussion of *seven traps of thinking*, or the common fallacies in scientific research. The moral of Selye's paper was that only if proper thinking and experimentation precede the writing of the paper will it have a chance of being worthwhile.

Assenting to Selye's principle and drawing upon my own experience and my own outlook on science, I shall indicate the prime factors to be considered in writing a scientific paper.

## Significant Intent and Content

Both content and intent of the paper should be significant for science. Science is a major human endeavor consisting in discovering and in organizing knowledge and in developing an understanding of Nature. It consists in methods for obtaining such knowledge and development of such understanding, including an attitude of mind so pervasive and distinctive as to be called a way of life. Science does not stem from sporadic forays or gallops into experimentation as weekend endeavors, or attempts to satisfy one's own superficial and fleeting curiosities. In a sense, it is at best a way of life, the result of a kind of perennial way of looking at things practiced by a wide group of men who are willing to be as different from other persons as may be required. Since considerable indefiniteness is possible in common views of science, what is written as a scientific paper may

easily be far from it. Scientific writing is more than mere reporting of facts. Facts are endless in number, so selection among them must be exercised in light of some principle or purpose. The time has passed when the reporting of a few interesting facts justifies space in a scientific journal.

## Exposition, not Narration

The scientific paper, of course, should be expository, and not narrative and casual in form.

## Report and Theory

The scientific paper may be either *reportorial* or *theoretical* in emphasis. From what was said about the significance of scientific papers, it can be inferred that the paper is not a mere reporting of information. Some theoretical significance must always be evidenced. Scientific endeavors have continued long enough by now to be organized. There is some background for almost every area of research or interest in which one might become involved. Few areas of intellectual concern are utterly unique and unrelated to some field of present knowledge.

Much of science consists in *seeing connections* between facts or phenomena, in *interpretations* so as to interrelate the maximum number of phenomena, in being able to *anticipate* what will happen in new kinds of situations. Although much is made of prediction, and whereas it has tremendous practical utility, it is not prediction for its own sake that represents the central ideas of science, but prediction as anticipation of new orders of understanding. This is what Selye calls discovery. Hence, theoretical papers have a significant place in science journals. Although there ought to be some speculation in all papers, certain papers wholly devoted to theory are highly appropriate.

## Inclusion of Reference

What has just been said leads to a more specific statement regarding orientation of the paper. It should refer specifically to the work of others in the field and give evidence that the writer is aware of what is known, although he may not be able to confirm cer-

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tain previous findings. He may be able to show that a new interpretation must be put upon the facts in the particular area under consideration. In this connection, the writer should make it clear why he did what he did, and if conflicting results have been obtained, he should endeavor to discover and to disclose the reason therefor.

### Evidence of Sophistication

Another way of stating the qualities needed in a scientific paper is to say that it should represent the highest possible sophistication in the particular field. The paper is, from the broadest standpoint, primarily an effort to promote science, rather than to promote the individual. This can only be true to any material degree when sophistication is involved. Sophistication is at its highest only when relevancies are being dealt with both in the research involved and in the reporting of it. The novice does not know, on his own, what is relevant and what is not. He does not know what is crucial to a better understanding; hence, his laboratory efforts may be to little point without his realization of the fact.

### Conciseness

The scientific paper should be concise and closely written. In narration, fewness of words is not always a virtue. What may seem like redundancy often is contributory. In exposition, this is not the case, for it is not mere impressions that are being given the reader. Overdoing detail obscures essentials. In exposition, clear workable understandings are to be transmitted. Conciseness is urged for the readers' sake, but there is another reason for it. With the many scientific and technical journals published these days, there is not room for nearly all the articles that are submitted. The more concise, the less waste of space, the more articles can be accepted.

### Simplicity and Unity

No single paper should be intended to make many points. The choosing of a unit of work or material to publish is more than an incidental matter. If an article reports only a small portion of one's recent work in a given area, thus requiring several articles to report all of it, one might be accused of making such a choice in order to enhance one's list of publications. If one were to go to the other extreme, the total report might either be excessively long, or so superficial as to be of greatly reduced value. Some elements of work tend naturally to form units and when so, there is little or no problem: break the

work into reports according to natural units. There are other times, however, when the division of material may seem arbitrary. It would seem then that one should assemble his material in light of the prime points to be made, the reader group to be dealt with, and the length of articles allowed in journals reaching one's chosen reader groups. Varied problems actually dealt with in a single investigation do not always belong together in the same written paper. Ingredients should be assembled meaningfully and to some purpose. Things should be kept as simple as possible.

### Appropriateness of Journal

The article should be placed in the *appropriate journal*, or, to put the matter the other way around, the paper should be *appropriately formed* for the journal chosen. There are times when the limitation lies in the availability of journals. If one's material is to be published anywhere, it may be necessary to publish it in one of a limited number of journals. That being the case, one starts from this fact and writes his article to fit the chosen journal. Although it is the editor's prerogative to say which articles do and which do not belong in his journal, choosing of the appropriate journal is one of the author's responsibilities.

### Knowledge of Editorial Policies

Every scientific journal observes certain forms and follows certain editorial policies. Its format involves policies of style, such as the use of passive or active voice, subdivision of the article into problem, apparatus, procedure, results, and discussion sections. Some journals require an abstract to be placed at the beginning of the article. Others require the final section of the article to be the summary. Some journals require submission of manuscripts in triplicate, although many require only two copies, and some ask only for the original copy. Some ask that the manuscript be triple-spaced rather than double-spaced. One of the policies in which there is considerable but diminishing variation concerns the form used for citations and reference lists. Some journals use citations in footnotes which, of course, are generally to be typed on pages separate from the text of the manuscript for the typesetter's convenience.

### Choice of Verbal Style

In writing any paper, the verbal style is open to considerable variation. For example, if one is writing for a homogeneous audience, and one which is well informed in the area of one's work, much can be

taken for granted, and terms which might otherwise need to be defined can be used without such explanation. While there are hundreds or thousands of journals, many of them do not have fully homogeneous groups of readers. Articles published in these cover a variety of interests. This being the case, some papers are read by some of the journal's readers, and others are read by still other persons. Facing this fact, the question of how broad a group of readers one wishes, or can expect, to reach is immediately relevant. It might well be concluded that usually an article should be written to reach as many readers of the chosen journal as possible. This means that, in spite of all that has been written about brevity and conciseness, the author must ask himself whether readers will be familiar or unfamiliar with prime words or terms he is inclined to use. Thus, in writing the paper in words best understandable to a broad group of readers, he must define more terms than when writing only to associates. The editor could be expected to judge, to criticize, and to accept or to reject a manuscript on the basis of whether it reaches only a restricted portion of the journal's readers. If the author is aware of this problem he can be more effective, and, at the same time, avoid editorial criticism.

Finally, it should be emphasized that the paper should lack all traces of having been hurriedly written. It should be the author's reasonable best, rather than his first or second draft. When the editor finds that the exposition is garbled and that points to be made are not well thought out, it is certain that the paper should never have been submitted in that form. These remarks issue from my own experience in having read many papers submitted to certain scientific journals for the determination of acceptance or rejection.

### Correspondence Between Title and Content

As a reader of scientific journals, but particularly as an associate editor, I find papers whose titles and content do not well tally. It is common to see titles such as the following: "The crucial influence of A upon B," and then to discover that the article shows that A has no influence on B. Obviously, the title might better have been: "The lack of influence of A upon B." A number of possibilities of mis-titling articles occur. Articles are catalogued in terms of their titles. Hence, if one is aware of this, he may influence how his article will be indexed and catalogued in various lists and files. This helps to make a real difference between those who will discover that the article has been written and those who can make use of it.

### Illustrations and Tables

These two forms of presenting data serve different purposes. If it is the purpose of the author to show broad relationships in a graphic and understandable way, graphs serve. On the other hand, if it is his intent to provide concrete quantitative data that are quickly obtainable by readers for their use, tables are necessary. This is because no graph that has been reduced in size to fit a publication is quite as accurate as a table of numbers, nor is it as convenient for obtaining numerical information. Don't crowd graphs; put some information in the legends.

### Plans of Publication

For fear that some authors are not well aware that some scientific journals provide two plans of publication, this fact is here pointed out. In addition to the regular plan, in which each author takes his turn in the calendar of publication (first article accepted being first to appear), there is a plan providing "immediate publication." This plan is workable because the author pays for the extra costs or the total costs of production of his article at a stated page rate. As soon as his article is accepted, processing can begin. Reprints of this article then are soon available and the article is added to those already printed, and as soon as enough pages have accumulated, the articles are bound as a volume. This means that such journals may issue a variable number of volumes per year, depending upon the number and the length of papers accepted. Other journals vary in the number of pages per issue, depending upon the number of articles accepted, the variable factor being the number of immediate-publication articles accepted. Publication lag in some scientific journals has come to be, or has long been, quite great, reaching as much as two years. Authors must be aware of this lag for the journal selected, particularly when timing of the article's publication is of crucial importance. Again, if a series of articles is to be published, it is well to have the several separate papers appear in proper order.

### Summary

The writing of a scientific paper consists not only in verbally reporting a set of facts, but also in choosing what is appropriate to write about. The whole process begins when one decides what to investigate in the first place.

Once an article has significant material to convey, there are several rules to follow, some of which are different from those used in other forms of writing. The present article points these out.

## Preparation of the Clinical Report

Russell N. DeJong, M.D.

Ann Arbor, Michigan

THE CASE REPORT has been called the foundation of clinical medical literature. It occupies a singular but important place in scientific writing. Much of our current medical knowledge is founded upon information which was originally presented in the form of the clinical description of a single case or of a small group of cases. In many instances such a report has served as the stimulus to further investigation and amplification, and thus has brought about the broadening of our scientific horizons.

The preparation of a satisfactory case report, however, is not simple, and may take as much thought and judgment as the writing of a medical essay or the describing of the results of extensive research. Many of the clinical reports which are submitted for publication have imperfections and deficiencies which make it necessary for the discriminating editor to reject them. Often such a report is the work of a novice in medical writing and is poorly prepared. As such, it abounds in medical jargon and poor diction, and may contain irrelevant details, unimportant and negative observations, confusing abbreviations, and ambiguous statements. Such a poorly written report adds little that is of value to medical literature.

Only occasionally is a single case worth reporting. In general, it should be a novel and individual condition, which, as ascertained through a fairly detailed review of the existing literature, has not been previously presented. In this day and age it is exceedingly rare to find a condition which has not been recorded and discussed before, and anyone who feels that he has stumbled upon something novel or obscure should investigate prior publications thoroughly before claiming originality or hurrying into print. There are, however, situations in which a single case or a group of cases may be reported even though there is current literature on the subject. This may be to call attention to unrecognized manifestations of the condition, to remind a journal's readers of certain aspects that may cause diagnostic confusion, or to add to the knowledge of its treatment. A well written clinical report, made with discrimination and judgment, is always welcomed both by editor and by reader.

From the Department of Neurology, University of Michigan Medical School.

The clinical report must be scientifically accurate and its grammar and diction should be clear and lucid. The author should revise and polish it until it compares favorably, both in technical and in literary aspects, with more detailed and extensive medical essays and reviews. It should never be copied directly from the original records that were hastily jotted down at the time various events occurred.

Usually, the report begins with a brief review of the disease or clinical syndrome under consideration, or of closely related conditions if the syndrome is unique, and a statement telling why the author believes it is desirable to report the case. References to existing literature on this or similar conditions may be included here, but these should be limited to those of real significance and should be accurate and follow the style of *Index Medicus*. If a comprehensive review has been published fairly recently, it is often sufficient to cite this, adding only the more recent references or those which the author desires particularly to emphasize.

The case report itself may follow next. It should be clearly written with only necessary data included. Separate paragraphs may be devoted to the patient's history, family history, physical examination, laboratory investigations, course, results, and, if available, the postmortem observations. Use of the patient's initials or of hospital case number is undesirable. Negative observations, redundant statements, and unnecessary material should be omitted. The author should use short, accepted, simple words. There is no place for medical slang or colloquialisms in any scientific article. Solecisms, vague and inaccurate terms, and circumlocutions should be avoided. Ab-

### The Author

RUSSELL N. DeJONG,  
M.D.



stract words should not be used as concrete ones, and nouns should not be used as verbs or adjectives. Only standard abbreviations should be used.

In citing a few common errors, it is important to bear in mind that the practicing physician often uses many terms and expressions which are ungrammatical and can only be termed medical jargon or colloquialisms. These may be useful in brief, informal discussions and in hurriedly written notes which are often a part of a patient's record, but they are inappropriate in scientific publications. Such phrases as "acute abdomen" and "right heart" have no place in medical literature. A case is an instance of disease, whereas a patient is a human being afflicted with disease. Operate, in medical usage, is an intransitive verb and we cannot "operate a patient." Surgery is an abstract term and should not be used to indicate a surgical procedure. Nor should a noun be used as a verb, as in "to staff a patient." Adjectives describing disease states and pathologic conditions themselves should not be used to refer to individuals so afflicted, as in "two leukemics" or "three meningiomas were admitted to the hospital." It is better to use terms such as girl or woman and boy or man rather than male and female. Trite and overworked phrases should be avoided and simplicity of expression should be sought. If the patient died, one should say so, and not seek for euphemisms such as "came to exitus," "had fatal termination," or "his respirations ceased." Emponyms should be used only if they are more widely accepted than corresponding anatomic and pathologic terms. Reports of consultants and those from clinical and pathologic laboratories are often attached to a patient's record; these are not written for publication and should not be incorporated into a medical article verbatim. If information from them is to be included, the original report should be re-written and woven into the fabric of the paper. Abbreviations are often confusing, and have different interpretations at various locations and to different specialists. P.A., for instance, may mean pernicious anemia to the internist, paralysis agitans to the neurologist, or postero-anterior to the roentgenologist. The abbreviation EEG, widely used today, has been used to refer to the noun for the instrument employed, electroencephalograph, to the noun for the recording, electroencephalogram, and to the descriptive adjective, electroencephalographic.

Well-selected illustrations may add to the value of the report and bring out or emphasize factors that cannot be described as adequately by the written word. They should be used, however, only if they

constitute a contribution to the report, and then should be clear, reproducible, and accurately labeled. Legends should be descriptive but brief. Charts and tables may also present material more clearly and more vividly than the text itself; if such is the case, they may be incorporated into the report. However, they should be few, simple, properly captioned, and contain no confusing details.

The description of the case or cases may be followed by discussion. In this, the author can synthesize, correlate, and emphasize important and salient features of the cases described. Herein, they can be compared or contrasted with previously reported cases or with similar cases from which the present ones must be differentiated. Outstanding manifestations of the syndrome should be brought out, and essential clinical, diagnostic, clinical pathologic and pathologic features stressed.

The discussion is often followed by a brief summary and conclusions, although on many occasions neither of these may be necessary for a case report. Statements made in the introductory paragraphs should not be repeated in the summary, but the summary should briefly recapitulate observations made, conclusions presented, facts that can be derived, and deductions arrived at from evidence presented in the paper. To write a good summary is no easy task; many revisions may be necessary if it is to serve the purpose for which it is intended. However, a summary, if clear and concise, is usually appreciated by the busy reader. A few brief, well-worded conclusions may follow the summary. These are more effective if numbered, but if numbered they should be coordinate in structure and in presentation. Conclusions should be used only to clarify and to condense salient facts of and deductions from the presentation and should not be mere repetition of discussion and summary.

To conclude this short consideration of one of the important aspects of medical writing, the author would like to stress that, due to the need for brevity, only the major aspects of the clinical report have been mentioned. Anyone who wishes to prepare a medical manuscript of any type, including a clinical report, should have available, and be familiar with, a few of the outstanding references that have been prepared for medical authors. These include, among others, "Medical Writing" by Dr. Morris Fishbein, "Guide to Medical Writing" by Dr. Henry A. Davidson, "Rx for Medical Writing" by Dr. Edwin P. Jordan and Willard C. Shepard, and "The Physician-Writer's Book" by Dr. Richard M. Hewitt.

## The Role of the Librarian in Intern and Resident Writing

Chloe S. Brewer, A.B.

Detroit, Michigan

TWO IMPORTANT functions of the hospital librarian are to aid the resident who is writing a paper by helping him to find source material and to prepare a formal bibliography. If it is a statistical paper, he should have statistics reported from other hospitals of comparable size and standing. Should this paper be an essay type, he should know what other persons have said on the same subject. If he is presenting a case report, he should see how many cases have appeared in the literature, how they were managed and their ultimate outcome.

The interested hospital librarian wants to see the literary neophyte write a good paper, with properly constructed sentences, variety of vocabulary and correct punctuation. The hardest thing to do is to get him started—"just put something down on paper," we say to him. The first paragraph is always the most troublesome, as it is to the majority of authors.

After the first roughdraft is made, he should read it to the librarian. She can make constructive suggestions; and the author, himself, may see many places where it could be improved. If he has been too didactic while writing on a controversial subject, the librarian will point out to him that he must document his paper. References from notable physicians who are of the same opinion should be accurately cited. He may cite references contrary to his stand and endeavor to refute them; or if he is broad-minded and can conscientiously do so, he may concede the opposing opinion the possibility of also being right.

There are many colloquialisms used in medical writing that could be eliminated without making the author's style stilted or dull. All of us know that the clear, simple style is the most readable. The selection of apt words, short and to the point, projects the author's meaning best. How to select these words

without making his style "choppy" is hard for the resident, as it is for almost anyone else.

When the galley proofs are received from the journal to which the resident has submitted his paper, the librarian can render a concrete service by reading them. It is mandatory that one person, other than the author, read the proofs for errors. The author is so familiar with his subject material that he reads it "correct" even though it may contain typographical errors.


May we make a plea here for absolute correctness in the References to all papers of residents, interns and physicians in general? The librarian is most likely to note these errors because of her experience with bibliographies where incorrect volume numbers are assigned to journal titles, incorrect paging and incorrect years. If these are all wrong, she must start from the beginning and use the standard indices; but when one or two items are wrong, the confusion is greater. These inaccuracies are not confined exclusively to small publications but occur in aggravating numbers in national periodicals.

Not only is the hospital librarian interested in the residents' publishing good papers, but she realizes that the hospital is represented in medical literature, by the published works of its residents and staff. She would like to have it said, "That must be a well-written paper because it comes from such-and-such a hospital." She, of course, is no judge of the medical and surgical standards of the hospital's work, but its style of being reported can be improved by her constructive criticism.

The current opinion is that too many papers are being published. There is always a place for a really good paper, and the hospital librarian has a small part in assisting in the production of such work.

*(List of references for this paper will be found in the amalgamated list of references on medical writing for all papers in this special issue of THE JOURNAL on page 234.)*

Mrs. Brewer is Librarian, Oscar LeSeure Professional Library, The Grace Hospital, Detroit, Michigan.



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Thanks to your prompt treatment and the smooth action of Deprol, her depression is relieved and her anxiety and tension calmed — *often in a few days*. She eats well, sleeps well and soon returns to her normal activities.

## Lifts depression...as it calms anxiety!

**Smooth, balanced action lifts depression as it calms anxiety...rapidly and safely**

**Balances the mood** — no "seesaw" effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient — *they often aggravate anxiety and tension*.

And although amphetamine-barbiturate combinations may counteract excessive stimulation — *they often deepen depression*.

In contrast to such "seesaw" effects, Deprol's smooth, *balanced* action lifts depression as it calms anxiety — both at the same time.

**Acts swiftly** — the patient often feels better, sleeps better, within a few days.

Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly — often within a few days. Thus, the expense to the patient of long-term drug therapy can be avoided.

**Acts safely** — no danger of liver damage.

Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function — frequently reported with other antidepressant drugs.

**Dosage:** Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

**Composition:** 1 mg. 2-diethylaminoethyl benzoate hydrochloride (benactyzine HCl) and 400 mg. meprobamate. **Supplied:** Bottles of 50 light-pink, scored tablets. Write for literature and samples.

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## *attains* activity levels promptly

DECLOMYCIN Demethylchlortetracycline attains—usually within two hours—blood levels more than adequate to suppress susceptible pathogens—on daily dosages substantially lower than those required to elicit antibiotic activity of comparable intensity with other tetracyclines. The average, effective, adult daily dose of other tetracyclines is 1 Gm. With DECLOMYCIN, it is only 600 mg.

## *sustains* activity levels evenly

DECLOMYCIN Demethylchlortetracycline sustains, through the entire therapeutic course, the high activity levels needed to control the primary infection and to check secondary infection at the original—or at another—site. This combined action is usually sustained without the pronounced hour-to-hour, dose-to-dose, peak-and-valley fluctuations which characterize other tetracyclines.

TETRACYCLINE  
ACTIVITY  
WITH  
DECLOMYCIN  
THERAPY

dosage  
150 mg. q.i.d.

TETRACYCLINE  
ACTIVITY  
WITH OTHER  
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PEDIATRIC DROPS, 60 mg./cc. in 10 cc. bottle with calibrated, plastic dropper. **Dosage:** 1 to 2 drops (3 to 6 mg.) per pound body weight per day—divided into 4 doses.

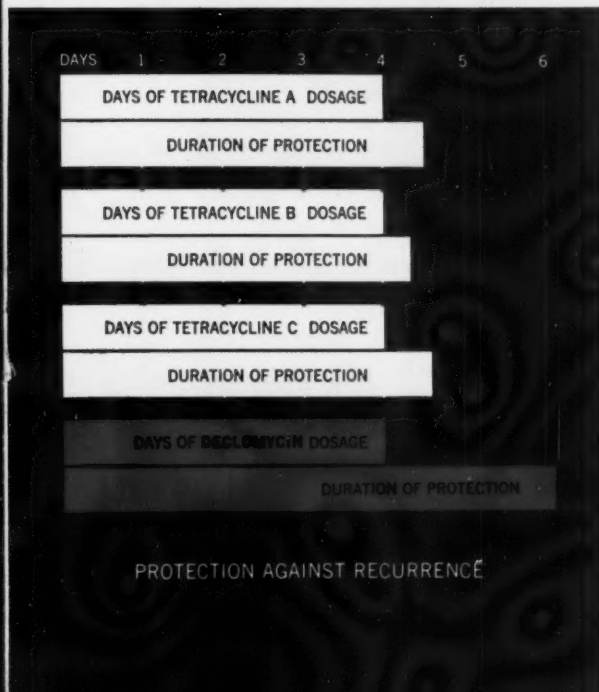
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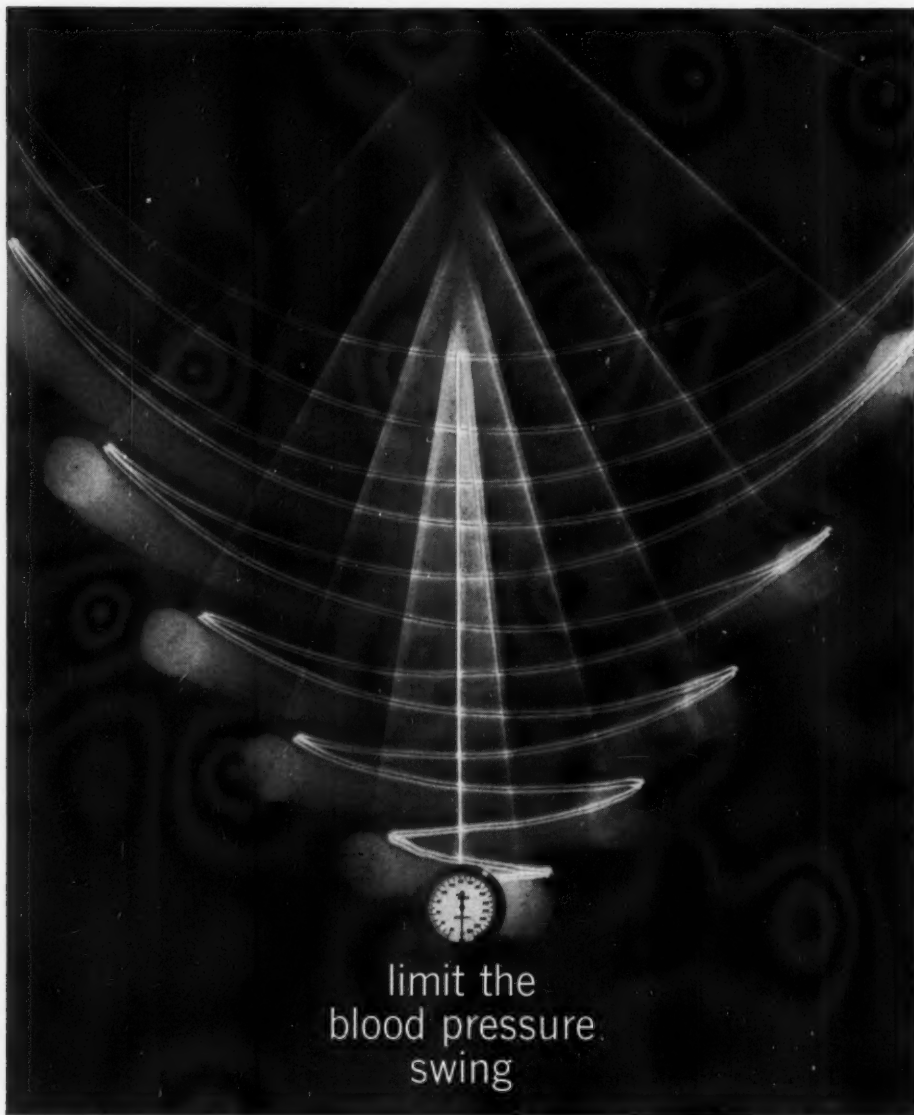
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# The Medical Library and Medical Writing

Ruth Good

Ann Arbor, Michigan

WHEN a physician-author looks around a well-stocked medical library he may be impelled to ask himself, "Is my article really necessary?" From the thousands of medical journals that pour into libraries every month, he might assume that writers have already said everything worth saying—and a lot that is not. But if he still feels that he has some new evidence, or a new view of established evidence, chances are that in all those publications he would find no piece exactly matching the one he plans to write. Medicine itself is so complex and dynamic that its literature can only grow and ramify, and any valid contribution helps strengthen the branches.

The medical library is the doctor's chief ally in his effort to produce a good sound piece of writing. The help the library offers is twofold: In the first place, it supplies rich sources of reference materials, as well as personnel to guide the doctor in his search. In the second place, it indirectly offers valuable instruction in the techniques of medical writing. The first function is recognized to some degree by all medical school graduates and undergraduates, but the second is apparently not so generally appreciated. It is conceivable that if all medical students were trained to use the library's resources fully and competently, medical literature might be considerably reduced in quantity and improved in quality.

Luckily for the physician-writer, the intricate science of medicine has been well documented for at least several hundred years—the first printed medical bibliography was published in France in 1506. Medical bibliography became established as an important branch of medical science with the definitive work of German scholars in the latter half of the eighteenth century. In the United States, achievements in this field have stemmed mostly from the work of John Shaw Billings, who built up and catalogued the Library of the Surgeon General's Office after the close of the Civil War, and established the *Index Medicus* in 1879. This index was the standard reference work until 1916, when the American Medical Association started the *Quarterly Cumulative Index*. The inevitable duplication between the two indexes led to their amalgamation in 1927, the result being the *Quarterly Cumulative Index Medicus*.

Then came the *Current List of Medical Literature*, which was issued at first as merely an interim guide, and was sponsored by a group of scientists known as the Friends of the Army Medical Library. Later, under the auspices of the Armed Forces Medical Library, this index came into wide use as a permanent record and the only one that was really current. In 1956, the Armed Forces Medical Library became the National Library of Medicine, continuing to publish and improve the *Current List*. The summer of 1959 marked the end of an era, when the *Quarterly Cumulative Index Medicus* ceased publication; the final volume in the series is the one covering the latter half of 1956. The *Current List* then changed its name to *Index Medicus*, appropriately harking back to the momentous labors of Billings and others in mapping the field of medical literature. The monthly series of the *Index* is published by the National Library, and the yearly cumulative index is a joint project of the Library and the American Medical Association.

For the medical writer, the significance of this background lies in a point that is perhaps taken too much for granted: The establishment of the bibliographic approach to medical literature has made it possible for the doctor to survey prodigious quantities of material in a relatively short time and in a relatively small library. It has also meant that medical libraries have become teaching and service institutions rather than mere repositories, a principle that holds whether there is only one librarian to fill all roles or whether there is a large staff of librarian-specialists. And, incidentally, developments in the handling of medical literature have brought to medical schools the need for changed concepts; the schools are beginning to incorporate classes in medical bibliography as a separate discipline taught by qualified medical librarians. In time, such courses may replace the Journal Clubs that now serve to acquaint medical students with periodical literature in their field.

Essential to good medical writing is a solid acquaintance with the work that has preceded the author's in his special field, and so the writing can be considered to begin with a thorough search of the literature, both current and historical. The aver-

age doctor is familiar with general reference works such as the major medical indexes, encyclopedias, and dictionaries. He is aware also that the librarian will go to any lengths to obtain the material he needs. If he is writing an article that requires the citation of basic sources, he can often expedite matters by first combing his favorite texts, as well as by reviewing articles and monographs in his specialty. He should of course take complete notes on references he finds in such sources so that either he or the librarian can locate the original material promptly. He will find abstract journals, such as *Excerpta Medica*, *Chemical Abstracts*, and *Biological Abstracts*, useful for surveying recent developments in a field. Government documents, unpublished dissertations, special monographs, and rare books and periodicals usually lie in the province of the medical librarian and the inter-library loan service. Librarians can produce miracles for an author if only he provides enough key information about his needs.

When he arranges his material, the author will find that his working bibliography contains several times as many references as he needs for publication, and as his article takes shape he must boil them down to a requisite few. Here let him take heed of an immutable principle: Any source he refers to must have been read by him. If his information comes from an abstract or a digest, let it be so noted. If he quotes an ancient scholar from a modern history, let this source be fully credited. Above all, let him shun the practice (which no librarian would ever be a party to!) of lifting references en bloc from another author, saving labor but perpetuating error and inanity.

The actual writing begins in the library with the first notes the author puts on cards. He probably has worked out his own system for recording and abstracting his reference material; if not, or if he is seeking more effective ways to do it, he can find excellent suggestions in print. But whatever system he uses, the paramount requirement is absolute accuracy. Then there will be no need for him to puzzle his brain over inconsistent or impossible data, at midnight in his favorite hideaway two hundred miles from the library—or for some copy-editor later to waste his spirit in the search for nonexistent authors or articles among the references. There in the library, at the beginning of his work, the author can establish once and for all the correctness of every letter and numeral in each reference. He should retain in his notes and incorporate in the finished manuscript all pertinent bibliographic information: for journal articles, the full authorship, whole title, complete pagina-

tion, and the volume, month, and year; in addition, for books, the correctly spelled names of editors, publishers, and places of publication. It is better to include too many rather than too few details in a reference list sent to the editor of a journal.

On the basis of its general purpose and content, the article will fall into one of about six major categories of medical writing. The author would do well to spend part of his time in the library scanning similar types of articles strictly from the standpoint of writing techniques rather than content. Is the material clearly and logically organized? Does the language seem graceful, and, if so, how is this accomplished? Are the mechanics of grammar and punctuation handled competently? He will find article titles ranging from a cryptic word to a full-blown, fatiguing summary, and should note that the best ones have not more than eight or ten carefully chosen key words. He should examine introductions: Do they acquaint him with the reason for the articles and make him interested in reading further? And summaries: Do they review the contents adequately, so that they could stand alone as abstracts? If an author finds himself actually unable to distinguish between good and bad medical writing, he should seek help, for the sake of his own writing. Through the medical indexes, he can find many articles and books dealing specifically with writing techniques; these are copiously illustrated with samples of good and bad medical writing. He might take home with him some books by gifted authors (for example Osler or Zinsser) and read them slowly with his ear tuned to style rather than information. Simple practices like these can constitute a thorough course in medical writing.

When a doctor is toiling over an article, it may be hard for him to envision the finished product as an integral part of the tremendous literature that embodies all the creative ideas of medicine since the art of healing began. Yet there it will be, for better or for worse, his contribution to the process described by one sensitive librarian as "establishing our ties to the past and making our promises to the future." It is the responsibility of the medical library to maintain the vitality of this process, and the privilege of the medical writer to draw concepts from that source, distill them in a new form, and return the essence to be drawn upon in turn by others. Thus the medical library and medical writing form an inseparable symbiotic relationship.

(List of references for this paper will be found in the amalgamated list of references on medical writing for all papers in this special issue of THE JOURNAL on page 234.)

# The Medical Abstract

Don Chalmers Lyons, D.D.S., Ph.D.  
Jackson, Michigan

WITHOUT the aid of available compilations of abstracts, medical authors and research workers today would find their task of investigation of comprehensive source material and precedents almost impossible because of the accumulation of hundreds of thousands of published articles. Search for previously published reports on a method, a technique, a discovery, or a precedent is extremely important if one would avoid the embarrassment that comes, too frequently, to investigators who publish without such careful background examinations. Such investigators have claimed new procedures, which to their later horror they have discovered were claimed and published many years before. This is especially true when earlier publication was in some other language.

Considerable confusion exists as to what is an abstract. Dictionaries of contemporary usage, in general, fail to define abstract in accordance with present use of the term. A difference should be noted between abstract and summary, conclusion, report, brief, and synopsis. Each of these forms has its own use, place, and characteristics. The one attribute they have in common is brevity. Directions issued by Biological Abstracts as instructions to their cooperating abstracters include a suitable definition: "An abstract should be a non-critical informative digest of significant content and conclusions of the paper, not a mere description. It should be intelligible in itself without reference to the original, but not intended as a substitute for it."<sup>\*</sup>

The most important guide, then, calls for the abstracter to be non-critical and at the same time to tell a complete story. No matter how much he may disagree with the author's published conclusions, the abstracter's job is to make a truly "informative digest" that is intelligible. With the present flood of new drugs, new techniques, and new uses, it is often difficult to digest a poorly documented article. Authors frequently write without adequate documentation, thereby creating difficulties for abstracters who are expected to "digest significant content and conclusions."

<sup>\*</sup>Biological Abstracts, 31(1):5-6, 1957.

Acceptable abstracts are written in established form. The abstract should begin with a statement of the complete title of the paper. If the paper appeared in a foreign language journal, the foreign language title should follow the English title. The second line should carry the author's name, his affiliation and his address, if these are distinctive; even though these often are omitted when printing space is limited. The original article usually carries the author's affiliation and address, or these are available from the editor or from directories to readers interested in communicating with the author. The third line carries the name of the journal and is followed by the issue number, first and last page numbers, a notation regarding illustrations, and the month and year of publication. This line is the most important part of the heading. It should be stated whether the journal is issued irregularly, quarterly, monthly, or weekly.

Some volumes are broken into sections or parts, and pagination may not be continuous, or it may be continuous through several issues or by annual volume. These facts should be carefully noted. It is extremely important that journal title abbreviations used be those generally accepted by *Quarterly Cumulative Index Medicus*, *Periodical Index*, or *Biological Abstracts*. JAMA usually refers to *The Journal of the American Medical Association*, but it could identify, to others, *Journal of the American Manufacturers Association*, *of American Metal Abrasives*, or of the *American Mortuary Association*. The following is an approved form actually published:

An evaluation of the effect of cerebral palsy on  
dentofacial development, especially the occlusion  
of the teeth.

Lyons, Don C.

Jour. Pediat., 49(4):432-436, illus., 1956

The body of the abstract should state briefly, in complete sentences: the object of the paper and reported investigation; methods; apparatus; drugs used; and the author's (not the abstracter's) evaluation of new data, of theories, of techniques, and of results. No graphs, charts, tables, or illustrations should be included in the abstract. The abstracter may mention

that there are such in the article. Reference may be made also to the bibliography if this is extensive or noteworthy in any other way.

The abstracter should realize that the abstract is a tool used by many readers of varied interests who speak other languages; for this reason, as well as for avoidance of error, few abbreviations should be used.

Abbreviations should be limited to those of universal usage in all languages and accepted in scientific literature, including perhaps: pH; cc; ml.; C, or F, for temperature; %; BMR (for basal metabolic rate); ECG, EKG (for electrocardiogram); EEG (for electroencephalogram); oz.; RQ (for respiratory quotient); and others of this type. Grams and grains can be abbreviated, but too often g can refer to either, and gm. and gr. come out the same on the linotype machine. Species and genus names can be abbreviated; but S. might refer to *Streptococcus*, to *Staphylococcus*,

to *Spirillum*, or to *Spirochaeta*. So, unless meaning is obvious, it probably is better that the abstracter not abbreviate and that he leave abbreviations to the editor.

The abstract should not contain detailed descriptions of new apparatus or of experiments. This should be left to the summary and to the review writer. New chemical formulas should be written out; but proprietary names of drugs and chemicals should be avoided. When absolutely necessary to use these, they should be identified with the proper symbol. Terms used to describe surgical operations should follow terminology acceptable to the American College of Surgeons.

Finally, the abstracter always should write with accuracy, brevity, and clarity, remembering that the more specific the words used, the more information they carry.

## Drunk Drivers Often Alcoholic

In the current *Michigan State Bar Journal*, Melvin L. Selzer, M.D., instructor in psychiatry at the University of Michigan, says: "A few long overdue studies now appear to implicate the alcoholic rather than the casual drinker" as a highway hazard.

In 1948-49, he notes, nearly half those convicted of drunken driving in Sweden were alcoholics. A Canadian study indicated that a group of alcoholics accounted for two-and-a-half times as many accidents, nine times as many convictions for drunken and impaired driving, and six times as many license suspensions as would be expected in the general driving population.

Several independent studies of personality factors in alcoholics and accident-prone drivers suggest that "auto accidents and the alcoholic personality are often associated," says Dr. Selzer.

"It appears likely that a substantial percentage of motor vehicle accidents are caused by alcoholic persons. It is also possible that many persons arrested for driving while intoxicated are alcoholic.

"In view of their inability to stop drinking unaided, they represent a unique challenge in that they offer law enforcement agencies an unusual opportunity to prevent future accidents at the hands of the same potential offenders."

Three factors have resulted in failure to capitalize on this opportunity, Dr. Selzer adds:

1. *Public Hostility Toward Alcoholics*: In their handling of alcoholics, the courts and law enforcement agencies not infrequently permit themselves to be ruled by hostile and irrational considerations.

Remanding an alcoholic to jail, fining him, threatening him, or treating him with derision and contempt may satisfy legal and personal requirements, but actually represents a disservice to the alcoholic and above all to the community.

2. *Failure to Recognize Alcoholics*: This has been attributed to both the chronic inebriate's skill at disguising his drinking problem and the public misconception regarding typically alcoholic behavior. However, the alcoholic's intense unconscious denial of his alcoholism is an important factor.

3. *Lack of Adequate Treatment Facilities*: Many jurisdictions are forced to rely solely on jail sentences and ordering offenders to attend Alcoholics Anonymous meetings because little else is available.

"Although Alcoholics Anonymous has done a remarkable job with countless individuals, its appeal is limited to alcoholics who probably constitute a small minority of the alcoholic population," Dr. Selzer comments.

"Alcoholics Anonymous successes have deservedly received great publicity in a previously not very hopeful area of human misery. But this and the unavailability of other facilities have made too many professional persons regard AA as a panacea for alcoholics.

"Necessity is often the mother of conviction. AA has thus unwittingly become a bottleneck toward further progress in the treatment of alcoholism."

Where ordinary legal threats and punishment fail, coercion aimed at forcing the alcoholic to seek treatment will often succeed, Dr. Selzer says. "Indeed, compulsory means appear to be the only way to bring the majority of alcoholics into treatment."

# The Medical Essay

Charles Sellers, M.D.

Detroit, Michigan

FROM time immemorial, man has had a restless, inquiring mind and a wandering body. He has migrated to the most distant areas taking his knowledge and opinions with him. He also has an inclination to write about his inquiries, his wanderings and his observations. His writings take many forms including essays on various cultural factors which generally contribute to a better understanding of different people and to an eclectic selection of cultural values from many sources.

The medical essay is restricted in scope. Perhaps a definition would be an artful approach: this makes it possible to select the grounds for discussion, to claim a degree of specificity and to disclaim certain territory which may be untenable because of pitfalls.

The title, "The Medical Essay," is simple enough to be disarming and ambiguous enough to be disconcerting. It may mean different things to various persons. Perhaps the negative side can be stated more easily. For our purposes, the medical essay is not a history of medicine, a résumé of the literature and a report of a rare condition or circumstance, a description of an operative technique, a dissertation on a familiar disease, treatment, procedure or drug, or an analysis of 700 cases of a particular diagnosis on a hospital chart run through a computing machine. It is not a statistical report of the incidence of beri-beri in Buncombe County nor the number of web-toed Eskimos in the Mackenzie River Delta.

On the positive side, the medical essay involves a discussion in a field where there are elements of doubt and speculation. It may be an approach to the solution of some problem or a theory concerning the resolution of a previous uncertainty. Generally, it is a philosophical treatise on a controversial subject or one in which knowledge is incomplete and there is an opportunity for an attempt to marshal an array of evidence or argument for a particular viewpoint, or for all viewpoints. Perhaps we may say that a medical essay deals with or covers a wide concept in a narrow field.

An essay might be written about medical education, the carcinogenic factors in pulmonary malignancy or theories about the etiology of cancer in general.

There would be an opportunity for stating personal experiences and opinions in each category. An essayist needs freedom to roam about in an unrestricted manner in a limited area, a playing field where he may volley ideas back and forth or take them from others and make efforts to reach successful goals.

On the other hand, a discussion on the familiar subjects of appendicitis, tonsillitis or Colles' fracture would not be suitable material on which to base a medical essay. There is no longer much mystery about these conditions. Their solution has been recent enough to be common knowledge and not remote enough to elicit romantic images.

Great events of the past in medicine make available to the medical essayist almost unlimited material for his consideration. Here are opportunities to revive little-known romances of medicine, splendid ideas and ideals, investigation of the unknown, research that proved to be fruitless and the brilliance of those that were triumphant. He can delineate a wide perspective and contribute to the general advancement of knowledge and culture by means of the written word in spite of the fact that some attrition takes place in competition for time and attention from potential readers.

*The printed page is congealed thought* transmittible as such to distant points and persons and reducible to its pristine state by readers. The medical essay should help the physician in his search for wisdom, which has been defined as a fleeting illusion, a universal perspective and an integration in time and space of those persons and events considered to be significant for all time. The essay aspires to be educational to the physician and of service to medicine. It may be used to stimulate a student to be a better physician by being a better man and to realize that he must be a good man before he can be a good physician.

Various kinds of essays have appeared in medical literature from early times wherever there was medical knowledge. In America, Oliver Wendell Holmes, of Harvard, became justly famous for his contributions to medical writing. His paper, "The Contagiousness of Puerperal Fever," which appeared in 1843 was almost simultaneous with a similar statement by Sem-

melweis but antedated Pasteur's demonstration of bacteria and knowledge of contamination by pathogenic organisms.

Another paper by Dr. Holmes, entitled "Borderlines of Knowledge in Some Provinces of Medical Science," was given as a lecture in 1861. It fulfills the description we have adduced for an essay as indicated by the title. A collection of the two mentioned and other essays appeared later under the general title of "Medical Essays, 1842-1882." These articles show familiarity with classical and medical literature and considerable experience in writing. They are descriptive and explanatory but perhaps a little verbose and contrived.

Sir William Osler frequently was asked to address various assemblies including the graduating classes of colleges in Canada, in the United States and in England. These usually took the form of essays on subjects tangent to medicine. Those published include "Acquaintance," "The Leaven of Science," "Chauvinism in Medicine," "The Hospital as a College," "Man's Redemption of Man," "A Way of Life" and many others. Most of these essays were written before Dr. Osler left the United States for Oxford. Some of them dealt with current problems of that time but many are timeless and quite as cogent now as then.

*The Journal of the American Medical Association* has carried excellent medical essays at various times. We might suggest that *The Journal* devote itself more to articles of a general nature, those with broad viewpoints, presenting arguments or the philosophic approach to many-faceted problems. Technical and

procedural papers then would gravitate to the specialties' journals.

William Dock, of Brooklyn, contributed a fine essay entitled "Curiosity, Culture and Curricula" to *The Journal* [JAMA 172:7 (Feb. 13) 1960]. He made a plea for the undergraduate medical student's study of the humanities and of social and of natural sciences during all the years he spends preparing to become a physician. He prefers the campus setting that is slightly removed from city distractions. Variety in medical education is more important than uniform "ideal" curricula and there should be better library facilities for individualized self-education.

William B. Bean, of Iowa City, wrote a splendid essay called "The Natural History of Error" published in the *AMA Archives of Internal Medicine* [105:2, (Feb.) 1960]. He says errors often are rampant and some wax and wane in a cyclic manner. In many instances, invalid opinions have prevailed long after contrary evidence became available. Consider: acidosis, autointoxication, viceroptosis, focal infection, tonsil excisions, thymus gland anomalies, "vitamania," and too implicit belief in the printed word and in intentional hoaxes.

A good medical essay should transport the reading physician on a journey across time and space amid ideas and images couched in liting language for his cultural enrichment and for his scientific enlightenment.

The essential thing is not to have arrived but to have travelled.

## Heart Research in Detroit

A study in Detroit of three great riddles of heart disease—including the basic problem of how to make a heart transplant "take"—will be financed by a grant of \$226,941 from The John A. Hartford Foundation, Inc., of New York to Harper Hospital.

The grant will support three years of research at Harper and Wayne State University College of Medicine, with which Harper is affiliated.

Richard J. Bing, M.D., Detroit, will direct the project.

The specific goals are:

1. To study the physiological reasons why a transplanted heart (or other organ) is usually rejected by the body within a short time after transplanting;
2. To develop a reliable and fast method of measuring blood flow through the coronary arteries; (this is badly needed for diagnosis and care of patients with atherosclerosis, and particularly for patients who have suffered heart attacks) and
3. To study the metabolism of the heart and other factors involved in angina pectoris.

# Medical Writing for the Hospital Bulletin

W. S. Reveno, M.D.

Detroit, Michigan

ALTHOUGH the Hospital Bulletin is essentially a house organ and its circle of readers is ordinarily small, it can serve the hospital staff as a medium for the exchange of experiences and the junior staff as a training ground for medical writing. Its contents need not differ greatly from those of the average medical journal. The costs of publication, however, place a limitation on size, number of illustrations and the use of professional help in the preparation and editing of manuscripts.

In the main, a Hospital Bulletin should be made up of short papers dealing with the following subjects: (1) case reports, including limited citations from the literature and a brief pertinent reference list; (2) reviews of certain types of cases prepared annually by the senior resident of each major department under the guidance of his chief; (3) preliminary, interim and final reports of clinical as well as laboratory investigations; (4) papers presented by visiting clinicians and by participants in staff-sponsored symposia on live medical subjects; (5) abstracts prepared by staff members of papers they have submitted elsewhere for publication; (6) brief reports on papers heard at national or regional meetings that would not appear in print for several months; and (7) a

*Festschrift* or memorial number when the occasion arises.

All of these fit into the Bulletin format readily, but editorializing has little place in such a publication, and personal items detract where the subscription list extends beyond the immediate area of the hospital.

To be acceptable for publication, a manuscript should deal with a selected or assigned subject in approximately 2500 words. It should include a minimal review of the pertinent literature with a brief reference list, and conform to the generally accepted rules governing the physical characteristics of manuscripts.

A middle road between undue verbosity that overwhelms the reader and telegraphic reporting that leaves him breathless should be followed. Concentration on clarity, not cuteness, and a bending and blending of words and phrases to achieve that end will always be rewarded by heightened reader interest.

Since the manuscript is going to be short, the opening sentences might well give the reason for the report and enumerate the significant similar experiences of others. A description of the case or cases is then followed by a discussion of the salient points, and the entire presentation is then wrapped up with a neat summary or conclusion. The first or second draft of this manuscript should be reread after a few days so that the material may be rearranged if necessary, sentences rephrased, extraneous items deleted, omissions restored and spelling and punctuation corrected.

A Hospital Bulletin made up along the lines suggested and published at regular intervals, either in printed and bound form or as a few mimeographed sheets stapled together, can serve as an effective means of communication for the medical staff and as a training medium in medical writing for junior members. It is a worthwhile project for any sizable hospital staff.



*The Author*

W. S. REVENO  
M.D.

## The County Bulletin in Health And in Disease

### *A Brief Treatise Upon the Diseases Which Afflict or Threaten One of the Functions Which Make for a Coherent Profession*

Hazen L. Miller, M.D.  
Royal Oak, Michigan

WHEN a county medical society has outgrown its mimeographed news letter, it needs a Bulletin. This need will develop when the society approaches one hundred members. Communications then pose a problem which cannot be solved by meetings and by letters alone. Call it what you like (but be kind to it); a publication should come into being. It will soon prove its reason for being by providing contacts between members and by disseminating their thought. Announcements, the president's policies, committee reports of general interest, communications, minutes of meetings—all should be aired.

But most important is the editorial: the conscience of the Bulletin. If you ask anyone for an exact definition of an editorial, the chances are he will be hard put to furnish it. Webster's New Collegiate Dictionary defines it as "an article . . . giving the editor's views." So the editor and his men should have a store of views or ideas, preferably not entirely contradictory to each other. Without editorials, a Bulletin lacks identity, individuality and integrity; with them, it seems to live and to think and not merely to report. This should make it worth the editor's while to think ahead and to lay up a store of cogent thoughts to draw upon, or, better still, to extract them from his associates. Stated briefly on a well-spaced page or less, and given a compelling title and a by-line, editorials distinguish the Bulletin as a conscious, thinking entity in contrast to the vegetative publication with neither invention nor originality.

Editorials, of course, imply an editor. Indeed, the Bulletin would be an anencephalic monster without one. But when the qualifications of a good editor are considered, the smaller society newly planning a Bulletin may have qualms. For instance, any editor worth his salt (which in this case is the satisfaction of a good job well done) should have sound and tested principles. Unless he is prepared to recognize an issue when he sees one and to take a stand upon the principles involved, the publication becomes wishy-washy and meaningless. It would also help if

the editor has a talent for being always right in his judgments. But this is not essential if he is fair and gives prominence to those letters setting forth opposing views, letters which he hopes for but which usually never get beyond the corridor cramp at the hospital. Intestinal obstruction stops them.

Besides an up-to-date acquaintanceship with all current medical problems, another desirable attribute for this ideal editor is a thorough knowledge of the classics, so that he may confound his critics by citing "wise saws and ancient instances." And last, most important of all, he should be willing and able to write.

Improbable as it may seem, the chances are that there are at least two or three men answering this description in any medical society numbering one hundred or more. Your man may not be writing medical papers for the journals. He may not be much of an orator; in fact, he may abhor the effort of elocution. He may have taken little part in society affairs because he is probably introspective and prefers thought to talk. But he is around somewhere if you look for him. The laws of chance predict his presence. When you consider the extent of literary education to which a pre-medical student is exposed, you must concede that someone somewhere in any given fifty or one hundred doctors got the general idea of communicating with his fellow man through the medium of words.

This man, this editor, with, let us concede, a few faults, having now been discovered, should be given a free hand. He will find his kind. Homogeneity is essential in an editorial board. He and his staff will find recruits and eventually from them will come the man who makes the editor a real success; namely, the editor's successor.

All the work need not be done by the editor and his assistants. Members can be found to contribute articles of more than editorial length and to present collected facts as well as personal opinions. These may be members of state society committees, chair-

men of county committees or anyone whose experience and wide reading has made him an authority of a sort. Such special articles may be on professional courtesy and ethics, on third-party medicine, on relations with public health and social welfare agencies, on the many facets of doctor-hospital relationships—there is no end to the possibilities.

The most factual offerings which the Bulletin can present are abstracts of meetings, both those of the Board of Directors and those of the society as a whole. These should not be elaborate, but clear. They should give the reader opportunity to know what is going on except for actions stricken from the record and actions taken in closed meetings.

The one most effective way of catching and holding readers is the establishment of regular departments. Thus, one such column may be a continuing analysis of current medical news, or sidelights on community affairs, particularly as they relate to medicine. Reviews of literature of all kinds interesting to the doctor could make another monthly column.

Excluding sex and other tales of violence, humor probably has the greatest appeal to readers. Too many professional and technical journals suffer from ingrown gravity. But where can you find humor? Genuine humorous writing is rare; it takes a remarkably inventive and imaginative mind without the strait jacket of conformity or the inhibitions of disciplined respect for revered institutions; but it probably has done more than any other type of writing to open paths for free and original thought. Examples are found in Rabelais and Molière, Sterne and Cervantes. Says Leo Rosten in his foreword to the *Return of Hyman Kaplan*:

Humor is the affectionate communication of insight. (Satire is focused bitterness, and burlesque the skewing of proportions.)

Humor is, I think, the subtlest and chanciest of literary forms. It is surely not accidental that there are a thousand novelists, essayists, poets, journalists for each humorist. It is a long, long time between James Thurbers.

News releases, like most things which come easily and in profusion, are not worth much. The best of them come from medical organizations; but even these have a high Fog Index, are too verbose and often arrive just after the deadline. By the next month, they are like ancient history (except for being well-known). No matter how scarce original material may be, the editor should not let the Bulletin be a victim of that insidious disease, propaganda. He will get it from advertisers plugging for a great new pharmaceutical discovery and presenting their pitch in the

form of pseudoscientific reports. He will get it from press agents for some industrial institute trying to offset adverse publicity with respect to the effects of their product on the public health. Even politicians try to horn in; as will almost anyone with a special axe to grind. This easy source of copy, which makes of the Bulletin a tool, should be shunned.

Another debilitating disease of the Bulletin is triviality. It creeps in on personal items. Some one broke 80 for the first time at golf, or went to Chicago, or bought a new car, or caught a mess of blue gills. These are matters of little or no importance and require no thought. The reader's reaction is usually, "So, what?!"

The Bulletin should feature a President's Page as often as one is obtainable. Opinions expressed therein are those of the man who has been elected to lead the society. Consequently, they are endowed with prestige and respect. Fortunate, indeed, is the editor who has a president with opinions to offer and policies to present. These are the hormones which give his publication strength and virility.

Limited space does not permit a complete discussion of over-indulgence in advertising. This results in "adverdupois," a form of obesity in magazines which causes sluggishness and loss of interest. In order to preserve readability and a literary appearance, advertising should not exceed about 50 per cent of the space of the Bulletin. When genuine reading matter is staggered through a maze of advertisements, some simulating it and others on rigid cards or folding sheets, like maps or time tables, then that publication is on the downgrade. It has become little more than a catalogue which may while away the reader's time when he is otherwise unoccupied.

The county society should see to it that its Bulletin qualifies under postal regulations for second-class mailing privileges. These requirements are easily met.

### Conclusion and Summary

The county medical society Bulletin should have specific objectives if it is to justify its existence and if it is to lead a worthy, well-rounded, healthy and useful life:

1. It should keep the membership informed and be both timely and accurate.
2. It should stimulate interest in major medical issues of the day.
3. It should bind members of the county medical society more firmly together.
4. It should amuse as well as instruct its readers.
5. It should encourage better writing.

# Statistics and Medical Writing

G. Stanley Woodson

Vergil N. Slee, M.D.

Ann Arbor, Michigan

VIRTUALLY every article appearing in a medical journal today is a statistical paper. We are given reports of changing patterns of disease, of series of cases comparing methods of therapy, and of single cases which are of peculiar interest because of their nonconformity with the expected. The physician is faced with the problem of using, presenting and interpreting quantitative data.

This is not surprising, since we live in a world of numerical descriptions. Our communities are described in thousands of people. Of these, certain numbers or proportions are males and females, so many are young and so many are old. Ball players are given batting averages. Automobiles are rated in miles per gallon. The cost of living is given in comparison with past figures in order to show the trends of our economy. These are statistics used as pictures, compressing information into manageable size.

The future is unknown to us. Yet every day we are forced to make decisions involving future probable events. The decision as to the time to leave the house for the office is based on a statistical process. Starting with the desired time of arrival one makes quantitative allowances for the mode of transportation, the expected traffic, the problem of parking, the weather and other factors, finally selecting the departure time which will most probably meet the arrival schedule. This second aspect of statistics pervades our lives: statistics as a method for choosing between courses of action—making decisions in the face of limited information.

Since these two statistical processes, description and prediction, are integral parts of all our existence, it would be impossible for the medical writer to avoid them even if he should wish to give in to the average physician's professed aversion to statistics and suspicion of anything statistical. These attitudes are, of course, based both on lack of understanding and on experiences with bad statistics.

In a great deal of medical writing, the statistics

really are of the descriptive variety. Vital statistics, data on morbidity and mortality, and series of cases illustrating new disease entities fall into this classification. From these descriptive statistics, concepts of probability and prediction, which belong to a more sophisticated area of statistics, are inferred. This is often done improperly. Large series of cases and the events occurring in these series are read with the attitude, based on intuition plus a smattering of statistics, that "the bigger the series, the more believable are the data." And the corollary is reflected in the derisive attitude toward the "series of one case." But, paradoxically, we profess to be skeptical of "statistics" and we welcome the publication of reports of one or two cases.

Elementary statistical methods used in description are relatively straightforward, understandable, and easy to master. These methods include the proper formation of tables and graphs, the proper use of rates to make comparisons, and the application of simple rules such as "you can't average averages" (unless you properly weight each average). These statistics give little trouble.

The problem arises when one wants to use past experience to govern future action, to predict, to generalize. The appearance of formalized statistical methods for these applications, with the introduction of terms such as "probability," "standard error," "t-test," "chi-square," and the like, often produces the usual reaction to anything poorly understood—a reaction of suspicion and fear. This situation is relieved tremendously when one realizes the actual identity of the process involved in deciding what time to start for the office, how to decide what is wrong with the patient (the most probable diagnosis) and the best treatment (that with the best possible combination of "pros" and "cons" under the circumstances).

In establishing a diagnosis, the physician combines elements of medical history, physical examination, laboratory and x-ray findings, giving each a value based on research and on experience. The weighted combination of these findings (some positive and some negative) leads to the (probable) diagnosis. In in-

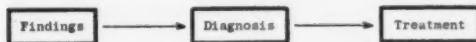
Mr. Woodson is the Biostatistician for the Commission on Professional and Hospital Activities, Ann Arbor, Michigan. Dr. Slee is Director of the Commission.

initiating treatment, the probable diagnosis, age, sex, complicating diagnoses, and other factors are considered along with the known properties of the possible therapeutic methods. There follows the selection of initial therapy based on the highest probability of success in curing the patient while doing him the least harm.

Statistical methods make systematic, orderly and quantitative these descriptive, estimating, predicting and generalizing processes. In medicine we make many such applications of statistics. For example, we determine five-year and ten-year survivals in cancer, we assay toxicity of drugs, and we evaluate their effectiveness. In the latter instance, medicine can justly be proud of its leadership in statistical methodology. The evaluation of streptomycin in treatment for tuberculosis is a statistical classic.

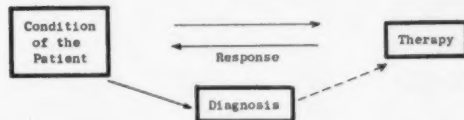
Another aspect of medicine is being considered through the statistician's eyes: medical diagnosis. Lusted and Ledley have offered a mathematical description of the diagnostic process. Their focus on this step in medicine appears to be a reflection of the traditional concept. (Diagram 1).

DIAGRAM 1



The more realistic diagram we propose (Diagram 2) indicates that labeling of the condition with a diagnosis is somewhat incidental to or at least parallel with decision as to management of the case, and that diagnosis and eventual therapy often depend on the effect of therapy.

DIAGRAM 2



On this basis, mathematical or symbolic representation of the care of the patient should be enlarged to describe actual processes employed by the physician.

With refinement and understanding of statistical methodology, there is a noticeable movement toward supplementing or replacing purely descriptive statistics with more refined and useful information. Most of the refinements are basically efforts to tell the reader how far and under what circumstances one can generalize from data presented. It is unfortunate that statistical methods have not become as familiar to the

medical reader as to the medical writer. The author is expected to write with simplicity, precision, and clarity. Statistical notation and presentation are often the best methods of meeting these requirements.

The conscientious physician-reader should realize that the trend toward using these remarkable statistical tools is only beginning and that it would be wise for him to invest his time and energy in learning something about statistical language, methodology and philosophy. To this end, a list of useful "do-it-yourself" references has been placed in the bibliography.

The questions of statistical content and quality of medical publications involve the editor as well as the author. Publication policies increasingly allow more freedom in the use of tabular, graphic, and symbolic modes of presentation recognizing that, while costly, they are essential. It is also becoming more common for medical journals to give papers submitted for publication to a statistical consultant or panel for approval in order to insure that the reader will not be misled by papers with bad statistics. This is indeed a favorable trend and should help to protect the medical reader from a great deal of worthless "information." Nevertheless, methods of review must protect both the writer and the reader against a statistician who, not quite understanding the situation, may turn down valuable contributions to the literature or approve, on a purely statistical basis, material which may be medically misleading.

Even more important than statistical review at the time a paper has been prepared for publication is the use of the statistician in design and conduct of research. His enlistment at this point is by far the best practice and it is increasingly being employed in clinical and laboratory research. This move early in the game provides assurance of mutual understanding between physician and statistician. A well-designed experiment will be far more economical, as well as more reliable, than one in which little or no attention has been given to statistical principles. The advice of Hewitt on this point is very sound:

If you contemplate an investigation that presumably will be sufficiently extensive to result in a paper much more complicated than a report of the case, you would do well to consult a statistician before you make any observations, do any laboratory work or collect any data. . . . If you are not a competent statistician and omit consultation with one who is competent, you may find yourself in crippling difficulty.

(List of references for this paper will be found in the amalgamated list of references on medical writing for all papers in this special issue of THE JOURNAL on page 234.)

## Illustrations and Graphic Methods

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**I**LLUSTRATIONS are an international means of communication. Well-prepared pictorial and graphic material accompanying an article in a foreign language gives the reader an idea of the content of the paper, even though he cannot read the characters of the written word. Photographs, line drawings, charts, original records and tables are introduced in scientific and clinical papers to give the reader a clearer concept of methods or relationships which he would otherwise have to obtain from long verbal explanations.

The majority of medical journals publish periodically a page of instructions for authors wishing to submit articles for publication. These instructions should be studied and adhered to rigorously. The purpose of this paper is to suggest ways and means of obtaining illustrative material and graphic methods which will be acceptable for publication.

### Photographs and Line Drawings

Many physicians do not have available the services of a visual aids department, thus they take their own photographs. A little pre-planning will produce results which are usually worthy of publication. Three important points to consider prior to taking a photograph are background, subject, and method of procedure.

A cluttered or "busy" background detracts from the center of attention (Fig. 1). In general, a solid or blank background is desirable. To eliminate an undesirable background, the objectionable part of the photograph can be painted with Chinese white (the eraser for India ink), or a line drawing may be made by tracing the important features on thin paper. Painting on a glossy print is difficult unless the area is first rubbed lightly with a small amount of saliva. This is more successful than using tap water. In deleting background, be careful to leave a base of support for the subject, especially if this is the way it appears in natural surroundings. At times, it may be desirable to design the background to show a rela-

tion between the object of focus (Fig. 2). This is particularly useful when patients are photographed at intervals to show progress under treatment.



Fig. 1. This photograph was originally 5 x 7 inches. Cutting two inches from the length removed part of the undesirable background. A part of the remaining background has been painted out with Chinese white to demonstrate how a photograph can be improved. Because permission for use of the photograph was not obtained from the persons, the faces were also painted out.

In photographing a patient, special attention should be given to his attire. Pictures of patients in partial stages of undress are neither pleasing nor professional. If a part of the anatomy is to be the focal point, drape the patient with the same care as that done for an operation. If the patient's face is to show, he should sign a release which will permit the physician to use the illustration for medical education or for publication. If release is not obtained, the patient's face should be covered while the photograph is being taken or blanked out on the print by covering it with Chinese white paint or a small piece of paper.

Standardizing a photographic procedure is of paramount importance when the purpose is to compare different patients or their affections, or progress under

From the Detroit Orthopaedic Clinic, Detroit.

treatment. Because considerable time may intervene between recording pictures, similar and dissimilar characteristics are readily observed if background, position of subject, focal point, lighting, and distance

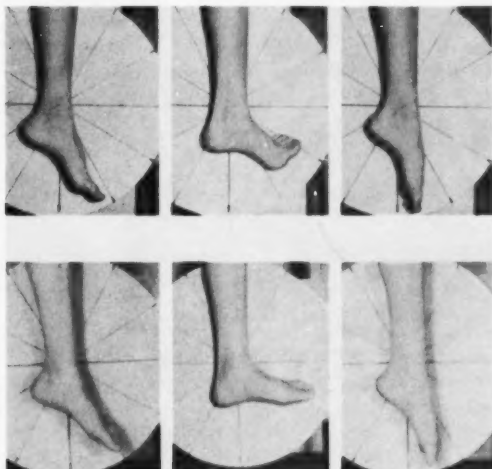


Fig. 2. The background was designed to emphasize the range of ankle motion before (above) and after (below) surgical intervention. (*Journal of Bone and Joint Surgery* 42-A:59-76, January, 1960)

from camera to patient are kept constant. Decide, before the first photograph is made: whether the patient should be standing, seated, or reclining; whether the camera should be on the same level, above, or below the central point; which type of illumination will emphasize the part or lesion illustrated; and whether the focal distance should be four or eight feet. Thereafter, use the same procedure for all subsequent photographs.

Depending on the subject to be illustrated, line drawings may be clearer and more descriptive than photographs (Fig. 3). Essential features of a photograph can be traced onto thin paper through use of an x-ray view box or similar transilluminating device. The tracing can then be transferred to heavy smooth pure white or blue-white Bristol board by blacking the back of the illustration with a soft pencil, placing it on the final paper, and going over the line drawing with a hard pencil. Another method of obtaining a line drawing is through use of an enlarger or a microfilm reader. The latter is found in many libraries. The enlarged picture may be projected directly onto Bristol board and the essential features outlined. This method eliminates transferring the drawing from thin to heavy paper. The drawing

should be finished with India ink and the paper cleaned with art gum eraser. Line drawings should be from two to four times larger than expected when published because minor irregularities become invisible during photographic reduction. The stippled effect of the Ben Day process may be produced by use of Zip-a-Tone which is available in a large number of patterns at most art supply stores. It can be used effectively and is easy to apply.

If services of a visual aids department are available, the physician should be certain that the photographer or the artist understands in detail exactly what the picture is to illustrate. Consultation with the photographer prior to his taking a series of pictures will insure the desired results.

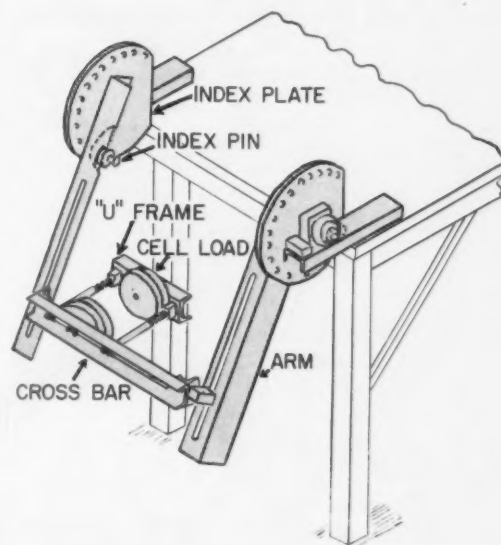


Fig. 3. This line drawing has been reduced from a  $5\frac{1}{2}$  x 6 inch illustration. The lettering is incorporated into the confines of the outline. Zip-a-tone was used to emphasize the important feature in the drawing. Lines under the table legs give the impression that the table is set on the floor and is not suspended in mid-air. (*Journal Applied Physiology* 11:475-480, November, 1957)

### Graphs and Original Records

A graph or a chart presents pictorially columns of figures, masses of data, or relationships which the reader can grasp quickly. Statistical material, in general, can be classified with reference to comparisons of size, to dates or time, to frequency or age distribution, to correlation between other factors, or to geographic distribution. Graphic presentation may be in the form of a bar, a pie, a curve, a scatter dia-

gram, a map, or a flow chart. In graphs having co-ordinates, the usual practice is to plot the independent variable on the horizontal axis and the dependent variable on the ordinate (Fig. 4). Dates or inter-

Remove the graph and connect related points on the chart. Then finish it in India ink and label. A drop bow pen is recommended for making circles; a ruling pen for straight lines. Placing a strip of adhesive

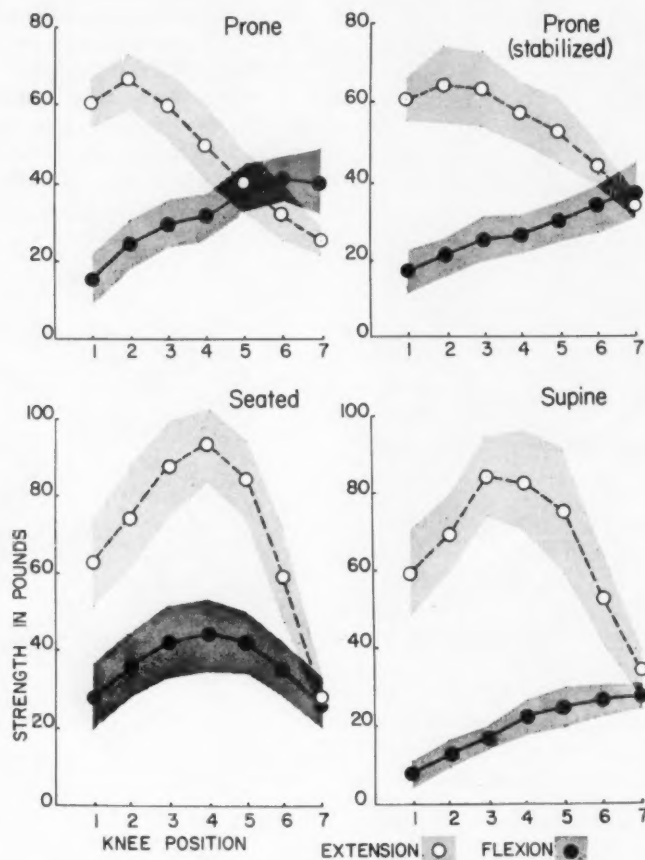


Fig. 4. Curve graphs which show one method of illustrating mean and standard deviation of the mean by use of Zip-a-tone. Because the co-ordinates are the same on all graphs, only one is labeled. The labeling was done with a LeRoy Lettering Set. (From same article as Figure 3.)

vals of time, in general, are plotted abscissa. The most important criteria for deciding method of presentation of data is that which best illustrates the picture clearly and simply.

After trying several methods for illustrating data, the clearest graph can be transferred from the work sheet on to Bristol Board in the following way. Place the graph over heavy white paper and with a pin prick holes in the points of the graph, the beginning and end of coordinates, and the scale on each axis.

tape on the underside of the ruler prevents ink from running under it. Ben Day process may be used to emphasize points as desired.

Pale background lines of all colors except red and black can be burned out by using contrast processed film during photographic reduction (Fig. 5). This special technique for removing background lines from original records and from graphs usually is not done by the printers publishing professional journals. If lines are to be deleted, the author or his institution

usually must bear the cost of reproducing a 5 x 7 glossy print. This then accompanies the paper for publication.

throughout the word. To avoid overcrowding the illustration with unnecessary labels, explanations should be put in the legend.

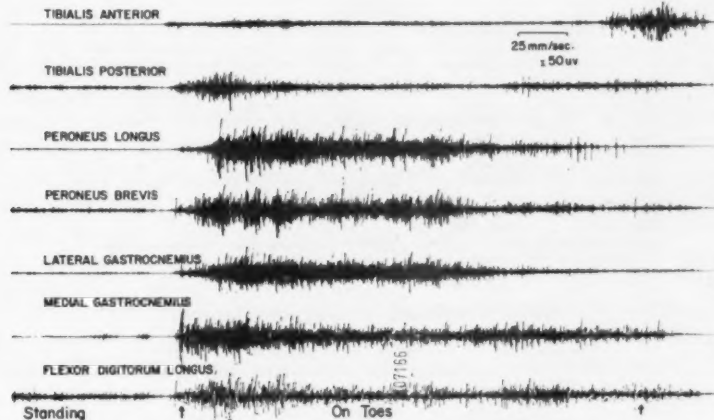


Fig. 5. Electromyogram reduced from original recording 9 x 14½ inches. The green background lines were burned out (notice chart number remains) by using contrast processed film when photographing the original record. This was done by a commercial photographer and the reduced 5 x 7 inch glossy print submitted for publication. Special processing usually is not done by the printers publishing the journal. (*Journal of Bone and Joint Surgery* 41-A:1469-1481, December, 1959)

### Lettering

Labeling for illustrations can be done either free hand or with a lettering device. The novice with a little practice will produce professional like letters by using either a LeRoy Lettering Set or the Wrico lettering guide. Use of a lettering device insures constancy both of size and of type of letters. Commercial Gothic or Modern Roman alphabets are the letters most commonly used for medical illustrations. In some instances, it may be possible to purchase from an art supply store printed letters, numbers, symbols, et cetera, which can be pasted onto the illustration.

Letters, when reduced for publication, should be easily read. Legibility depends on the size of letter, spacing, and distribution of ink throughout a word. Usually narrower letters are more difficult to read. The same is true of those which have greater width than height. Too little or too much space between letters reduces ease of reading. Because of optical illusions, round letters (O, C, G) should be closer to each other or to a straight letter (I, N) than when straight letters are placed next to each other. Slanted letters (V, A) occurring next to each other should be placed very close together. Lines of letters should be of the same thickness and of uniform degree of blackness

### Tables

A table is a short-cut means of presenting numerical data. It should be arranged to emphasize primarily one point or a single relationship. Generally tables present either original data which characterize patients or classify materials, or derived data which summarize or point out results (Fig. 6). For each type of data, there is usually one form of table which presents important points more clearly than any other arrangement. After condensing and tabulating statistical material to obtain clarity, every item should be checked and rechecked for accuracy.

Each table should be typed, double space, on a separate page. Three cross rules should be included: one at the top; one below the box heads; and one at the bottom of the table. Footnotes should be placed below this bottom line. Standard abbreviations should be used for column headings and these should be consistent each time they occur in tables.

### Summary

Suggestions herein presented are primarily to give the author a few "tricks of the trade." Additional information may be obtained in most books on medical writing listed in References which appear in this issue

of THE JOURNAL. It would be well to consult one of these as well as the list of suggestions supplied by the editor of the journal to which the paper is to be sent.

tional explanation in the text?

4. Is each table properly condensed to illustrate clearly one point or relationship?

TABLE II  
DATA ON PATIENTS WITH ANTERIOR TRANSPOSITION OF THE PERONEAL MUSCLE

Patient	Year and Month of Birth	Age* at Onset	Age* at Operation	Years between Onset and Operation
J.B.	June 1942	2	11	12
L.E.	June 1948	3	9	6
C.A.H.	April 1945	8	13	5
C.H.	January 1949	2	8	4
W.J.	June 1940	14	18	4
M.O'R.	September 1943	7	14	7
D.P.	May 1941	11	14	3
K.S.	December 1943	2	5	3
H.S.	October 1942	4	15	11

\*Ages given in nearest years.

TABLE I. SIGNIFICANCE OF DIFFERENCE BETWEEN MEAN STRENGTH AT EACH ANGLE OF FLEXORS AND EXTENSORS OF THE KNEE IN DIFFERENT POSTURES

Position	Seated— Prone— 31 tests*	Seated— Supine— 28 tests†	Prone— Supine— 29 tests†	Fixation— Free— 29 tests†
<i>Extension</i>				
1	0.44	0.68	0.41	0.22
2	2.01	1.19	0.78	0.30
3	6.66	0.68	6.35	1.01
4	11.69	2.23	6.88	2.24
5	12.54	2.70	14.24	3.92
6	6.83	1.28	5.11	4.71
7	0.71	1.70	4.39	5.92
<i>Flexion</i>				
1	4.46	8.34	3.95	0.63
2	4.21	9.50	6.45	1.58
3	4.28	9.47	7.11	1.87
4	3.94	7.45	5.59	2.87
5	1.38	6.47	6.69	3.86
6	2.63	3.89	8.30	2.91
7	5.48	0.79	5.68	1.04

\*t of 2.75 at 0.01 level.

†t of 2.76 at 0.01 level.

Fig. 6. Photographs of published tables set in type by printers of two journals. The "open" table is typical of those published in *Journal of Bone and Joint Surgery* (41-A:59-76, January, 1960). The "ruled" type is characteristic of *Journal of Applied Physiology* (11:475-480, November, 1957).

The following check list may help in preparation of illustrative and graphic material in connection with writing a paper for publication.

1. Do the illustrations and the graphically presented material contribute to clarity?

2. Do they present material effectively without written explanations?

3. Is each illustration with its accompanying legend, or graphic material with its heading, so clear it can stand alone as a complete entity without addi-

5. Is the lettering in the illustrations readable when reduced?

6. Do the illustrations and the graphic materials substantiate the purpose of the study and concur with the results presented in the body of the paper and in the summary?

If the paper is well illustrated, the author can devote the greater part of the text to comparisons, to inferences, to interpretation of data, and to discussion of results.

## Duties and Responsibilities of an Editor

Louis J. Bailey, M.D.  
Southfield, Michigan

IN DESCRIBING editorial or "news" policy for the small magazine of the county medical society, it is well to distinguish immediately between the identity of the editor of such a magazine and the editor of the usual commercial or smaller house organ. The editor of whom we speak will be an amateur almost certainly; he will be of the grass roots, as a rule, and will have been chosen because of his devotion to the science of communication and his already demonstrated willingness to give of himself in medical society affairs.

Let us also recognize that the reader public of this magazine is guaranteed to the editor since the publication automatically is a membership privilege.

So, with an amateur editor and a guaranteed reader public, what constitutes good policy?

The editor must be responsible to an officer or board within his society. Since he is appointed, he will be responsible to the president; in a larger society, he will be responsible to the Council; but always, matters of policy, whether official actions of the society, or simple decisions affecting editorial policy, should be decided jointly by the editor and by the officer or body to which he is responsible.

Further, if the editor is responsible to official policy as determined by the executive officers of his society, he is also responsive to reader opinion. His editorial policies will stem from needs and opinions of his readers. His purposes are to inform them; to hear from them; to organize them in respect to local effort; to orient them as a local society to their part in a broader program; to bring unity through information and news.

The news policy of the magazine must be calculated to fit the organization into the larger plan of which the local society is a part.

Statewide movements, national programs, activities

of lay organizations with medical purposes, all will require reporting, comment, and fitting into the local setting. Readers must be kept informed of these and, by editorial comments, of opinions and of policy within the society.

*The editor needs a road map.* How will the magazine be made up? What will be its content? Will it be uniform from issue to issue?

As you know, the *Detroit Medical News* frequently, though not always, has a lead article. There is an editorial, a listing of coming events, and special contributions, such as "By the Way" by Dr. Stapleton, and "Rant and Rave" by Dr. Lightbody. These have good reader interest.

Then, too, the official activities of the Council are reported at appropriate periods; some news events, capsule comments such as Dr. Reveno's "On the Run," book reviews, health department reports, and advertisements complete the book's content.

In earlier issues, *Detroit Medical News* had rather more reports on personal experiences, such as births, deaths, illness, and trips of doctors and their families, than we see today. It made for a folksier magazine of historical value. Such a magazine has little or no interest, however, for editors on exchange lists.

Reports of events and activities are of value. In former years, *Detroit Medical News* also received synopses of articles from the scientific literature—I believe from a clipping service. These made interesting and historically valuable reading.

Guest essays and editorials have their places. They provide reader interest and, at the same time, enlarge the number of your contributors. The guest editorial is a suitable substitute for thoughtful and thought-provoking readers' contributions in letters to the editor; and certainly, readers' contributions are to be courted. Readers feel that they are part owners and part managers of the publication. Readers' proprietary interest was mentioned earlier. Their views and comments should be integral parts of each issue.

The difficulty, of course, is to obtain carefully con-



*The Author*

LOUIS J. BAILEY  
M.D.

Presented at the Second Editors Workshop for County Medical Society Bulletin Editors, January 30, 1960, in Detroit.

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sidered and well-written constructive comment on issues of the day. An instance comes to mind of a particular atrociously written letter—with respect both to construction and to spelling—which appeared in *Detroit Medical News* many years ago. It was printed as written, rather obviously that it might serve as its own rebuttal to the views expressed by the writer. But, as pointed out in the beginning, the editor is an amateur.

All letters, even those with the negative point of view must be answered; whether they are printed should be left to policy determined by the editor, executive officer or board, or editorial board if this exists.

But in this connection, the editor must not lose sight of his responsibility for all that appears in his publication. In his writing, he will need good diction and proper syntax; he will do well to develop a style (preferably fairly uniform, whether this be gaily informal and chatty, or reserved and formal); he will scrutinize and pass on the quality of that which he accepts from associate editors and from contributors. But always, in the last analysis, he is responsible for all that appears in his magazine. To this end, news policy will include acceptance for printing those reader comments which conform to principles of propriety which he applies to himself.

*The editor should be objective.* Since he is part of the organization he serves, he is likely to share opinions which may be held in controversies or proposals which may be under discussion.

He may be drawn into a running series of commentaries by means of correspondence; but it is not the best editorial policy to engage in or to permit the periodical to become an instrument for such debate.

The editor should attempt to organize, to unite, and to inform. His editorials should present points of view provoking thought; they should avoid exploiting the editor's pet aversions and predilections.

It is the duty of officers of the society to deal with controversial subjects. It is the editor's duty to report thereon: to explain how official attitudes have been adopted; to inform in a manner helpful to members of the society.

Undefensible statements should be avoided. Often, in reading a contribution, merely asking if this or that statement can be defended can help the editor decide on the appropriateness of the publication. As the person solely responsible for all that appears in the magazine the editor must be assured of defensibility before he can accept controversial material for publication.

This is not to say that in comment on official action, the editor is a pusillanimous nitwit. For example, a comment on action of the Judicial Council of the American Medical Association will suffice to illustrate the point: An editorial thereon drew a searching questioning commentary from a prominent and responsible physician. The editor stated what he considered the basis for his point of view and was able to show that his wording had not stated that the Judicial Council was wrong; he had stated that the effect of the Council's action was so and so. The reader was left to judge whether this effect was good or bad, right or wrong, acceptable or unacceptable.

Use of words is a fine art and, while shades of meaning are not to be carried to a legalistic absurdity, connotation of written words must be clearly defined and defensible.

Possibility of libel should be mentioned. Just as the concept of the corporate practice of medicine is so frequently misunderstood, this *bête noire* of the amateur editor, libel, is misunderstood; yet it is easily defined.

Libel is the printing of that which may damage the reputation or defame the character of a person. The law protects individuals from scurrilous writing, direct or indirect; it does not apply to that which is true and in the public domain.

Editorial policy permits criticism of ideas and of things, but under no circumstances should it permit criticism of persons. Print nothing which might be questionable on these grounds.

### Summary

Editorial policy will include planning how the magazine is to be made up, what is to be included; reader representation and contribution will be sought; readers' comments, pro and con, will be thoughtfully and carefully answered, but the publication will not be used as an instrument of conflict which may disunite the society's members. The editor will keep currently informed, and advise his readers. Editorials will be written clearly and will avoid obscure or arch references to events or situations known only to the editor himself.

Editors might well look to the past of their periodicals: that which was good might profitably be reviewed and republished as of historic interest, forgotten but revived. Even the amateur editor will want to improve his publication, keeping it ever fresh, crisp, and new, but not entirely divorced from the past.

# New Approach in Doctor-Patient Relationship In a Government Hospital For Long-Term Patients

V. K. Volk, M.D., Dr.P.H.  
Saginaw, Michigan

THE IMPORTANCE of a close relationship between doctor and patient, based on free choice of physician, has been recognized for many years. In the past, these bonds were especially strong because the family physician supervised the health of the entire family and thus acquired knowledge and understanding of the needs and problems of each of its members. To these families, the doctor was more than physician; he was friend and advisor, even on problems which may not have had any direct bearing on health or sickness.

Although this type of patient-physician relationship is not as strong now as it was a generation ago, it still gives strength to our system of medical care. It has been weakened to some degree by extension of specialization. Contact with specialists is usually temporary and occurs only in special situations.

Currently, most patients with moderately severe or severe illness are hospitalized. Since many doctors are overworked, there is often lack of communication between doctor and patient with the result that many patients do not understand their own conditions. Certainly, this is a situation desired neither by patient nor physician; but often the patient accepts it uncomplainingly with confidence that the doctor will tell him of important things when necessary. Undoubtedly, the bridge of friendship between family doctor and patient helps to make up for any lack in communications.

A different situation exists, however, when the patient is admitted to a government hospital; no previous bond exists between the patient and a doctor he has not chosen. The hospital doctor, seeing the patient for the first time, tries to establish rapport. This imposes both burden and responsibility on the hospital physician. Usually, hospital staff doctors and hospital administration make a special effort to fill this gap.

This is not to suggest that care of patients in a

government hospital, either by full-time or by part-time physicians, is less adequate and conscientious than similar care of patients in non-government hospitals. The physician in a government hospital simply has more difficulties to overcome because of lack of earlier relationships. This problem is especially acute in a hospital for patients needing long-term care.

On the basis of many years' experience as an administrator of a hospital for tuberculosis patients, I initiated, in 1953, a program for better communications between doctor and patient. This program has been acceptable to all concerned and contributed to better understanding between doctor and patient.

Hospital care for tuberculous patients often is difficult because confinement frequently is dictated not only by treatment but also by public health requirements. Clinicians primarily interested in tuberculosis know that many patients believe they are well enough to go home and insist that they no longer need to be hospitalized.

Many have strong feelings about what they believe unnecessary hospitalization. Such suspicion in itself creates difficulties both for doctors and for hospital administration.

For instance, some patients talk of differences of doctors' opinions even though differences in clinical assessment about needs and conditions of patients have not been stated. Such conclusions have been drawn by patients because different physicians have different ways of analyzing patients' problems and of expressing their ideas in their own words. Although findings may be similar, differences in expression may be misinterpreted and create unpleasant situations.

Week-ends, when the regular physician may not be on duty, seem to be "field days" for some patients, because the physician on call usually is not in possession of detailed clinical data pertaining to each patient. Some resultant problems are easily resolved; but often decisions made under these circumstances are difficult for the patient to accept. Obviously, such situations could be prevented if certain basic premises obtain:

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Dr. Volk is Medical Superintendent of the Saginaw County Hospital.

1. Patients are entitled to detailed information about their illness and the hospital administration must provide relevant information.

2. Information given to the patient must be authentic and related to current status.

3. Resident physicians should be able to provide information at any time on the basis of collective judgment of the staff rather than upon the opinion of the individual staff physician.

4. Information must be available to the patients in writing because: (a) patients forget the spoken word, and (b) many interpret information through wishful thinking rather than by facing facts as actually given them by the doctor.

Others also need relevant information on problems presented by tuberculosis patients, public health aspects as well as medical: The health department needs to be kept informed on individual patients' progress; and family physicians, too, need to know about their patients' progress since during the period of hospitalization for tuberculosis they will have been out of touch with their patients.

Since 1953, to meet these needs and to establish continuous communications, letters have been written at regular intervals to each patient: (1) immediately after his case was considered by the staff, usually at the first staff meeting after his admission; and (2) every three months thereafter.

These letters are written by resident physicians and reviewed by the medical director of the Tuberculosis Division of Saginaw County Hospital. The original is sent to the patient; a copy is placed in the patient's record file where it is always available to all resident physicians; the second copy is retained by the resident physician dictating the letter; a third copy is sent to the local health officer; and the fourth to the family physician.

Letters to patients usually are concluded with this statement: "If you have any questions concerning this letter, or your case, please do not hesitate to contact me at any time." Many expressions of appreciation that come to us from family physicians indicate need for such information.

I believe much good has been accomplished by these letters. The patient recognizes the validity of the letter because he knows it is an official medical record; experience has convinced us that writing letters to patients every three months is good hospital practice, resulting in understanding and good will.

The plan in operation has resulted in some valuable by-products: when writing such letters resident physicians must be accurate; hence they must be thoroughly familiar with the patient's record and with his

condition at the time of writing; an economy of time results because the letters eliminates the necessity of answering the patient's questions about his condition from day to day for the doctor needs only to refer the patient to his letter. Information provided in the letter also helps nurses, practical nurses, and student nurses to understand the patient's needs.

Frequently, the question arises, "How do you write to patients about unpleasant developments?"

Certainly, not all patients get well, and some fail to be cooperative. It is easy to write pleasant things to patients when they progress favorably. When it is obvious that they are not making good progress, we are as frank in writing to them.

A few examples of letters sent to patients may be of interest. Some of these relate to the patient's condition on admission; others, to the course of the disease; and others, to discharge. Our several years' experience has demonstrated to our satisfaction that the procedure is worthwhile, with benefit to patients, to family physician, to health officer, and to resident physicians.

I have no hesitancy in recommending that other hospitals try a similar plan, which might even be appropriate for application to patients and to resident physicians in general hospitals.

### Conclusion

On the basis of our six years' experience, we find that letters written by resident physicians to patients have brought better understanding between doctors and patients; and that resident physicians, since they must be in possession of detailed information on the condition of each patient before writing these letters, are better informed about their patients.

### Letter Sent to Patient Soon After Admission

Mr. H. L.  
Saginaw County Hospital  
Saginaw, Michigan

Dear Mr. L.:

In keeping with the policy of the Saginaw County Hospital, each patient is sent a letter of information following the presentation of his case in regular medical staff conference. In this manner, the patient is kept informed as to the progress made during his period of hospitalization. This is your first such letter.

Chest disease in your case was first suspected in 1953, and thorough study of your case led to surgical operation involving the left lung that same year. Our records are not as yet complete, but I can find no evidence of active pulmonary tuberculosis at that time.

During the past summer, however, your physical condition and your chest x-rays showed changes suggestive of active, pulmonary tuberculosis, and you were hospitalized at St. Mary's Hospital on August 1, 1956. Although all tests at that time failed to show active tuberculosis, your physi-

cians quite wisely persisted in repeated examinations, in order to determine the exact status of your chest. Further studies completed at St. Mary's Hospital following your readmission on September 27, 1956, resulted in a positive diagnosis of active, pulmonary tuberculosis, and you were admitted to the Saginaw County Hospital on September 29, 1956.

Our studies confirm this diagnosis, Mr. L. Your chest x-rays have been thoroughly studied, and we have been able to find the germs of tuberculosis in your sputum samples. Treatment has been started and includes isoniazid and para-amino salicylic acid (P.A.S.), two of our most potent anti-tuberculosis medications. In addition to the medicines, you are receiving, you have been placed in an activity classification designed to measure and limit the amount of activity you should undertake. You are in Class D. In addition to the items listed on your classification card the following is worthy of emphasis:

1. Rest in bed as much as possible.
2. Use a wheelchair for all transportation.
3. You have limited time (prescribed) for sitting indoors and occupational therapy.

Do not overlook that first item, Mr. L. Rest and regular rest periods are equally as important to you as the medicines you are taking. Without sufficient and adequate rest these medicines cannot do for you all that might otherwise be expected of them. It would be impossible for me to over-emphasize this.

The medical staff is anxious that your period of hospitalization be a pleasant as well as a physically profitable one, Mr. L. If you have any questions concerning either this letter or your case, do not hesitate to bring them to me.

Sincerely yours,

\_\_\_\_\_, M.D.  
Resident Physician  
SAGINAW COUNTY HOSPITAL

### Letter to the Patient in Need of Surgical Operation

Mr. W. O.  
Saginaw County Hospital  
Saginaw, Michigan

Dear Wilbur:

Your case was again presented at staff conference on December 3, 1956. It was the opinion of the doctors present that the chest x-ray of November 21, 1956, showed no definite change in the lesion in the right lung. The sputum examinations still continue positive for tubercle bacilli. Your general condition is quite satisfactory.

As we have previously told you, surgical operation is still the procedure of choice and you still have not consented to this. You will, therefore, still continue in Activity E, and also with routine sanatorium care.

When you have any problems relative to your case, please do not hesitate to discuss them with us. We extend to

you best wishes for a Happy Holiday Season.

Respectively yours,

\_\_\_\_\_, M.D.  
Resident Physician  
SAGINAW COUNTY HOSPITAL

### Letter to Patient Following Separation Conference and Discharge

Mr. N. S.  
Saginaw County Hospital  
Saginaw, Michigan

Dear Nelvern:

This letter is written to record for you and for us the conversations we had at the time of your discharge from Saginaw County Hospital on July 18, 1956. As you know, you have been hospitalized at Saginaw County Hospital since February 15, 1955. The x-rays showed widely distributed disease in both lungs which has the appearance of tuberculosis of a type which had developed gradually over a period of years.

Although the disease has not been very active it has produced extensive scarring in the lungs. Although we have not found the germs of tuberculosis in the sputum, the x-ray evidence suggests that there had been many germs in your system producing the disease. As tuberculosis is a disease that continues for a long time and sometime causes trouble even after apparently having become inactive, it is important that you be aware of the possibilities of a future unfavorable change. In order to avoid such a change, it is necessary that you continue living each day with adequate rest including at least 2 hours of bed rest after the noon day meal and sufficient nutritious food that your health will be at its best.

As there is some light outdoor work which you may be doing when weather is good, I am sure you will have no need to try to go back to your work at least for several months. If later, a very light job under favorable working conditions can be obtained, it might be all right to go back to employment there.

While you were at Saginaw County Hospital, you were getting streptomycin and para-amino salicylic acid (P.A.S.). It will be somewhat difficult to take streptomycin which is given by needle after you are at home; consequently, we have discontinued this and you are to take isoniazid, which will be supplied to you in small white tablets, each tablet containing 100 milligrams. You are to take one each morning and one each evening. You will also continue taking P.A.S. to the extent of 20 tablets per day.

If at any time, you question whether everything is all right do not hesitate to come back to see us. If everything seems all right, I suggest that you come back on the 26th of October for re-check examination. With every good wish for continued good health, I am,

Sincerely yours,

\_\_\_\_\_, M.D.  
Resident Physician  
SAGINAW COUNTY HOSPITAL

# Amalgamated List of References On Medical Writing

J. P. Gray, M.D.

Detroit, Michigan

The several authors of papers published in this special issue of THE JOURNAL MSMS, in keeping with good practice in writing, cited references on medical writing. As one might expect, several standard references on the subject were cited by most authors. Conversely, several other published works on technical writing, of possible interest because of proved value, were omitted. In an effort to provide a good working list of references on medical writing, the editorial committee of the Michigan Chapter of the American Medical Writers' Association decided that an amalgamation of the several authors' citations, with duplications deleted and with some additions, mainly of basic standard resources, would serve most readers of THE JOURNAL better than repetitive lists appended to each article in the usual manner. In some instances, references were cited by individual authors on related fields, but these have been deleted, except for those related to statistics, since it seemed desirable to limit references to those relevant to medical writing to statistics herein.

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## Birth Defects—Cleft Palate

Nearly 100 per cent of the children born with cleft lip and palate can be helped by surgery, but it takes an entire team of health specialists to correct the physical and emotional effects of this birth defect.

James R. Hayward, D.D.S., oral surgeon at the University of Michigan Medical Center, says that cosmetic correction of cleft lip and palate is only part of the rehabilitation procedure. It is equally important to restore the child's ability to speak and eat, and to guide his mental adjustment to the defect.

For more than six years, the University of Michigan cleft palate team has combined its variety of specialized skills to restore children born with the disorder. The specialists represent pediatrics, oral surgery, otolaryngology, speech therapy, prosthetic, orthodontic and children's dentistry, and psychiatry.

The abnormality strikes one child in every 700, second only to clubbed feet in frequency. It occurs before the tenth week of pregnancy when the two halves of the upper jaw, which form the roof of the mouth and parts of the lip, do not fuse. The result-

ing gap widens as the embryo continues to develop.

Causes of the defect are unknown. Research, hindered by lack of funds, hints that one possible cause may be traced to heredity.

Within the first weeks after birth, surgeons restore the lip. They postpone the more extensive correction of jaw bone and soft palate until the child is about two years old. Dr. Hayward says too early surgery on the cleft palate may hinder further growth.

Cleft-palate team members keep a continuing check on the child's progress, often until adolescence: middle ear infections to which the victim is especially vulnerable require the attention of otolaryngologists; orthodontists straighten the jaw and teeth.

Normal speech is the ultimate goal in the cleft palate treatment, Dr. Hayward points out. Throughout the rehabilitation process, clinicians teach the child to develop speaking abilities. He says surgery alone can restore normal speech in only 10 per cent of the cases; most require extensive help in speech correction.

# The New Look in Food Poisoning Control

W. L. Mallmann, Ph.D.

East Lansing, Michigan

AS A BACTERIOLOGIST interested in environmental health and all ramifications of microbiology pertinent to the area, I am interested in the means of lessening food poisoning and food infection by the toxigenic staphylococcus, the infectious Salmonellae, and other microorganisms of lesser frequency and pathogenicity. I am also interested in solving the problem by every means available—by attempting the application of our scientific knowledge, through education, regulation by codes and ordinances, by development of better food equipment and by better processing and handling of perishable foods that sustain bacteria and serve as good sub-strata for their growth.

I do not propose to discuss pathogenicity, invasiveness, toxicity, nor the symptoms indicative of each organism, or the behavior of these organisms in food individually. I am interested in discussing the fact that while the incidence of preventable diseases has been steadily decreasing, the incidence of food poisoning and food-borne infections has remained at approximately the same level during the past decade.

Food-borne intoxications and infections are reportable in most states; however, only the large outbreaks are thoroughly investigated and reported. Many small outbreaks are never reported. Accordingly, the U. S. Public Health Service can list only a small percentage of the outbreaks and cases. An estimate, based on the reporting of perhaps 10 per cent of the cases, would yield a figure of one million cases a year, an astounding morbidity rate of 570.

Other environmentally spread diseases have been controlled: for example, typhoid fever. In 1900, this disease showed a mortality rate of thirty-six. The disease was spread primarily through sewage-contaminated water, although food and milk were also carriers. In 1913, in this state, we started eliminating sewage from our water supplies by building water purification plants and training people to operate these plants effectively. The program was slow, because we had to develop means of purifications, develop techniques for evaluating the sanitary quality of the water, and develop means of training people to become

operators. The tempo of activity gradually increased until after World War I, when the push for safe water began in earnest. Today the incidence for the United States is less than 0.2 and last year there were eight cases and no one died in Michigan from typhoid fever. Our water supplies in Michigan are safe. The fight to stop typhoid fever has succeeded, and this disease is a closed chapter, just as long as we continue to close all avenues of infection. The organism is still present in the sewage of our cities, so control must be continued, and just so long as regulations are maintained, the disease is under control. We have isolated the typhoid bacillus from East Lansing sewage and the Red Cedar River that flows through our campus, still we have no known carriers. I have always been curious as to its source.

During this same period, when preventable diseases have been lessened markedly by improved environmental conditions, a vigorous sustained drive has been made to improve food processing and handling to reduce food-borne intoxication and infection.

We know how staphylococci and salmonellae are spread. We know how to prevent their multiplication in foods. We have all the technical information that is needed to control these diseases, and still, we have not succeeded in reducing the incidence appreciably.

True, our population has increased and more people eat in public food establishments. In 1955, the National Restaurant Association reported the following kinds and numbers of eating establishments:

Restaurants, cafeterias, lunch counters, et cetera.....	194,123
Industrial restaurants.....	26,261
Hotels .....	15,100
Hospitals .....	6,572
	242,056

We spend nearly \$17 billion annually for foods and beverages outside the home. An average of 78 million meals are served daily in our varied food service establishments. Our health agencies are reporting outbreaks regularly, so it may be argued that incidence appears high only because more cases are recognized. This may be true to a degree, but if our methods of control were effective, a marked decrease should occur.

From the Department of Microbiology and Public Health, Michigan State University, East Lansing, Michigan.

To date, the approach on disease control in food service establishments has been largely a regulatory inspection based on a code and ordinance of required specifications and operations, subject to license. The inspection is devoted primarily to the physical aspect of the establishment. Although an educational program is frequently used, it consists of a series of two or three night lectures crammed with the "do's and don'ts" of food handling presented to the employees. At a completion of attendance, each attendant is rewarded by the issuance of a food card attesting his accomplishment of being present. He is now a full-fledged member of the fraternity with all the rights thereof.

The current U. S. Public Health Service Ordinance and Code Regulating Eating and Drinking Establishments which serves for the regulation of interstate food establishments and as a model code for states and cities, stresses the physical aspects in keeping with the inspection procedure. It is an engineering approach to a biological problem with little consideration of the biological aspects.

For example, the first item listed in the code is floors. "The floors . . . shall be of such construction as to be easily cleaned, shall be smooth, and shall be kept clean and in good repair." The health reason—"clean floors are conducive to clean food-handling methods."

The second item is "walls and ceilings." Walls shall be kept clean, kept in good repair and shall be finished in light colors. The health reason is the same.

The items continue on the theme of good construction, easily cleaned and clean, up to item 16—"cleanliness of employees." "All employees shall wear clean outer garments and shall keep their hands clean at all times while engaged in handling food, drink, utensils or equipment. Employees shall not expectorate or use tobacco in any form in rooms in which food is prepared."

In reading the Ordinance and Code, the impression could well be that a physically clean restaurant is an assurance that staphylococci and salmonellae outbreaks could not occur. The sanitarian or inspector making the inspections may give this impression unknowingly, and the operator may very likely believe that physical cleanliness of the establishment meets all requirements and the public is properly protected.

Through the code that accompanies the Ordinance are many "do's and don'ts" of food handling, so items of biological significance are presented but the emphasis of examination is the physical structure.

In all fairness to the sanitarian and the ordinances,

improvements in food service have been made in cleanliness, better equipment and ease of operation, but the glaring fact remains that the objective of the whole program—the elimination of disease transmission by food has not been accomplished.

Paradoxically, most of the outbreaks occur in the better restaurants, where clean operation is maintained. It becomes apparent that cleanliness *per se* is not the answer. Obviously, no one would defend the thesis that cleanliness is not, in part, an answer to good disease control.

If our present methods are not the answer, then we need a "New Look." The "New Look," in a sense, is a re-evaluation of objectives. What are we attempting—aesthetics—a pleasant place to eat—or public health—a safe place to eat? As health officials, the latter should be our objective; the former is the job of Industry.

Before setting regulations, the sources of the disease organisms should be considered. The toxigenic staphylococci are carried by personnel, who are in contact with the food. Boils, abscesses, throat and nose infections, or carrier states are the main sources of infection. The salmonellae may be found in intestinal discharges from infected persons or carriers, as well as in meat, poultry, eggs and dairy products.

Thus, personnel becomes the most important factor in disease spread and personal hygiene rates the first major step in a control program. Next, personnel must be trained in the handling and processing of food, they must understand the hazard of careless food handling, they must know the steps necessary to avoid food contamination and the means of controlling microbial multiplication.

Often in discussing food sanitation before health organizations, I have made the statement that 99.9 per cent of the problem is personnel. I have also stated that if anyone objects, I would be glad to argue a percentage of 99.999.

Personnel is thus more than employees who wear clean outer garments, who have clean hands, and who do not smoke or chew tobacco while working.

The job of disease control is not just a plant inspection—it is an educational project that must be planned carefully and executed in a manner that will train operators, particularly owners and managers, comparable to that attained in training water plant operators and dairy pasteurizers and bottlers.

On the premise that the causative organisms come from personnel and food, then the second item in a control program should be food quality. Meats from inspected packing plants, sea food from areas not con-

taminated by sewage, pasteurized milk, and poultry from inspected plants should definitely be required for public food service.

Salmonellae are frequently carried from the animals' intestinal tract to the carcass, through careless handling in the process plant. Federal, state or municipal inspection does not necessarily eliminate the presence of these organisms, but good plant sanitation and handling lessens the incidence. Inspection would also lessen the possibility of trichinosis, tuberculosis and other diseases transmissible to man from animal. In somewhat like manner, sea food gathered from unpolluted waters would be less likely to harbor the typhoid bacillus, the dysentery bacillus and other disease organisms, both bacterial and viral, that are carried in sewage. Comments on pasteurized milk are unnecessary, because only pasteurized milk is allowed in all food establishments.

The third item responsible in avoiding food poisoning and infection should be proper refrigeration. It must be remembered that in both staphylococcus poisoning and salmonellosis, the organisms must multiply in the food to high populations. This means that the temperature of food storage must be favorable to the microorganism, so that generation rates are high. Inasmuch as the food handlers have no idea of the presence of these organisms, or the degree of contamination, food should always be held at a temperature unfavorable for multiplication, where generation rates are exceedingly slow.

Present codes and ordinances specify a storage temperature of not to exceed 50° F. This temperature was set many years ago, when ice refrigeration was common, and it was impossible to attain temperature much below this figure, except in commercial storage houses. Foter and associates of the USPHS have demonstrated that salmonellae and staphylococci will grow at temperatures down to approximately 42° F. This means for extended storage, perishable foods in which these microorganisms can grow should be stored at a temperature of not to exceed 40°F.

In our present codes, we are concerned in refrigeration with checking air temperatures of the refrigerators, and looking for dirt and spoiled foods. In the "New Look" we, of course, check for these points, but we are more concerned in the use of the refrigeration; the size of the storage unit, the protection of the product by covers, and the period of storage.

Most epidemics are tied closely with personnel and refrigeration. Turkeys are responsible for more outbreaks than any other food. It is a large package, that takes a long time to cook, and a long time to

cool. Generally, the turkey is stuffed with an insulation material, consisting of bread fragments, chopped liver and other food stuffs, that favor the growth of these organisms. Sometimes the cooking time does not allow the development of lethal temperatures in the stuffing and so the contamination persists and multiplication takes place even with refrigerated storage. Cooling is slow and bacterial multiplication occurs because of the large package. To avoid the disease hazards of roasted turkey, the turkey should be split in two, so baking can be faster and complete. Stuffing should be baked in a separate pan. If the food is to be stored at refrigeration temperature, the cooling is rapid, and little, if any, bacterial reproduction takes place.

The turkey is a good illustration of a package difficult to refrigerate rapidly. The operator should be vitally concerned with rapid cooling, and so the control of food poisoning and infection lies in proper refrigeration, the proper size package, proper circulation, refrigeration capacity and period of storage.

Along with refrigeration, of course, is cooking. Foods must be cooked at a temperature such that lethal temperatures for pathogenic bacteria result in all areas of the cooked food. Cooking is not always the final means of eliminating health hazard, as the toxin of staphylococcus is thermostable.

The fifth factor in the "New Look" program is contact surfaces. Contact surfaces include all surfaces that come in contact with food products during the course of preparation and serving. Outbreaks of salmonellosis have resulted from placing cooked chickens on tables previously used for uncooked chicken contaminated by salmonellae. Here the program consists of presenting specifications and methods of cleaning and sanitizing.

These five factors are the key to a good program in preventing food-borne disease in our public eating places. The "New Look" is a plan to emphasize those factors directly responsible for causing or abetting food poisoning and infection. It is a plan of action carrying a minimum of minutiae. It is not an easy program to activate and maintain, but a plan that should pay dividends in disease prevention. At least, it is a new plan predicated on education and consideration of biological aspects of microbial disease transmission, and control of microorganisms.

This plan will be used in the development of the new USPHS Code and Ordinance. Every physician is invited to help in promoting better and safer food services in our restaurants.

Guest Editorial

# Wilfrid Haughey, M.D.

## "A Distinguished Editor"

THIS ISSUE of THE JOURNAL, planned for more than a year to emphasize medical writing, has dual objectives: in addition to presenting a series of papers on several aspects of medical writing by members of the Michigan Chapter of the American Medical Writers' Association, it honors Wilfrid Haughey, dean of editors, practicing



WILFRID HAUGHEY

physician, otolaryngologist, medical statesman, citizen of Michigan and of Battle Creek. The Michigan Chapter of AMWA is glad to join the Board of Trustees of MSMS in honoring Wilfrid Haughey, whose picture is on the cover of this issue of THE JOURNAL.

MICHIGANITE by birth and by breeding, Wilfrid Haughey was born in 1880. Following elementary and secondary schools education in Battle Creek, he had his pre-professional education at the University of Michigan and his professional education at Detroit College of Medicine, now Wayne State University College of Medicine, where he received his doctorate in medicine in 1906. After internship, followed by residency in Chicago Eye, Ear, Nose, and Throat Hospital, and by post-graduate work at Harvard Medical School, he served his country as a medical officer: he was a Lieutenant-Colonel in the United States Army Medical Corps, with the assignment Chief of Ophthalmology and Chief, Head Surgery, Base Hospital 36, France.

\* \* \*

NOW IN HIS eighty-first year, Doctor Haughey is actively in practice and serving as Attending Ophthalmologist and Otolaryngologist in the Community Hospital in Battle Creek. He has served as Consultant to the American Legion Hospital, as Chief of Ophthalmology and as a member of the Executive Board of Leila Y. Post Montgomery Hospital, and he continues to serve as Consultant to the Veterans' Administration Hospital, all in or near Battle Creek.

Long an active member of MSMS and for nearly twenty years editor of THE JOURNAL, he has served as Chairman of the Board of Michigan Medical Service. He has long been a Fellow of the American College of Surgeons, and active in other professional organizations including the American Medical Association, the Calhoun County Medical Society, the American Academy of Ophthalmology and Otolaryngology, and the American Association of Railway Surgeons. In 1960, Doctor Haughey was elected Fellow of the American Medical Writers' Association; and he has been an active member of the Michigan Chapter of AMWA during that organization's four years' existence.

\* \* \*

THE SOCIETY AND THE CHAPTER honor a distinguished editor, an outstanding physician, a prominent citizen . . . Wilfrid Haughey of Battle Creek, Michigan.

—J. P. GRAY, M.D.

EDITORIAL

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## Reading, Writing And Rewriting

Medical writing cuts across many disciplines, for the elements of good writing come from various sources and are inherent in much of the literature of the world. There are examples of superior writing from nearly all peoples and in all languages.

Some critics have said that medical writing is not as good as it should be because it lacks some of the human touch that tends to make reading interesting. It may be that in becoming more scientific and more exact, it loses some of its warmth. Generally it lacks expository references to the allied sciences and to the classical knowledge of the non-medical world. Perhaps it is narrow writing for narrow reading.

Medical writing calls for considerable confidence based on extensive knowledge and familiarity, preferably through personal experience and observation, with the particular data under consideration. Writing ability is enhanced by a background of extensive reading in general literature, in science, and in the classics. Homer, Plutarch, Cicero, Hippocrates, Voltaire, Bacon, Shakespeare, Spencer, Newton, and many others should be familiar to the writer. Great readers often become fine writers.

Duty drives some of us to read unattractive material on the premise that it must be good for us and because we need to know something about the particular subject. Bitter medicine has been prescribed on the same basis. If an author who has something to say because it interests him, can say it well, and quits when he has done so, he will have accomplished much. Unfortunately, some authors have written without fulfilling these criteria.

Most writers in medicine set out to describe some new observation, or procedure, or to present little known information. His presentation should flow evenly and develop his thesis in logical sequence. The material should proceed from the familiar to the unfamiliar. New statements should be relevant to previous assertions, as the evidence is presented leading to the conclusion for which the paper has been written, the climax.

Medical writing cannot always be simple; but it can be clear, concise and consecutive. It cannot always be colorful; but it can be precise, pertinent and purposeful. It cannot always herald a brilliant new discovery or concept; but it can be accurate, descriptive and observational. It cannot always be free from technical words and ideas; but it can be free from verbosity, split infinitives and dangling participles.

Putting the conclusion in the first paragraph may be suitable for journalists, but it is not justified in medical writing. Short clear sentences, with a minimum of

punctuation, generally read more easily than those containing interpolations, quotations, or parenthetical statements.

The most important factor in any kind of writing is clarity of expression. Style is largely a matter of personal inclination and preference. Great help can come from experience through frequent reading, continued writing and rewriting.

Easy reading is hard writing.

CHARLES SELLERS, M.D.

## Medical Writing

This issue of THE JOURNAL of the Michigan State Medical Society is devoted to Medical Writing and to the Michigan Chapter of the American Medical Writer's Association. The assignment and programming to produce this number of THE JOURNAL has been in process for over a year.

J. P. Gray, M.D., of the Parke-Davis staff, is responsible for the suggestions and the carrying through of the planning. Members of the Association and others were asked to provide papers which could be used in this issue of THE JOURNAL. These papers were written many months ago and submitted to a committee consisting of Dr. Gray, Charles Sellers, M.D., Detroit, and S. J. Houtz, R.N., Detroit, who reviewed them at a special meeting, did some editing, and had them retyped and prepared for the printer. They did a thorough and wonderful job.

Why select Medical Writing for an issue of THE JOURNAL? For the very good reason that the vast majority of medical communications, training, instruction, not to exclude records and the distribution of new knowledge, must come through the printed page. The American Medical Writer's Association has selected this aspect of medical communication as its particular bailiwick. It is often a discouraging task to induce a doctor to write a paper for presentation or for publication as we have found in years past. We believe, however, Michigan is well advanced in the area of medical writing, but we know how difficult the task is for some.

Just recently one of our prominent surgeons was bemoaning the fact that doctors, in spite of their elaborate preparation in premedical work, are loath to write anything. We are very happy to present this unique effort in medical journalism.

## Editorial Writing

Writing of editorials is an especially challenging and exacting part of the field of medical writing. During the years, THE JOURNAL of the Michigan State Medical Society occasionally has published a scientific editorial other than those in connection with the

special topic or area to which the particular number of THE JOURNAL is devoted. In general, scientific editorials demand a man of broad experience, a judicial character with an appreciation of the whole subject, and an ability to express himself well. That type of editorial writing is used on occasion but is limited largely to the specialty and special interest journals.

In a sense, THE JOURNAL of the Michigan State Medical Society is a trade journal. Its function is to pass on to the membership the scientific advances, administrative and other programs, news items of interest, comments, and enough material of various types to keep the readers interested. It has another function which is to interpret to the membership the philosophy, the goals, the accomplishments, and the socio-economic problems which involve the profession. This also demands a special type of editorial writing. It requires an intimate knowledge of what is transacting, of the problems to be met, the accomplishments which can be reached, and the means by which these ambitions may be attained.

The Editor must be able to select the timely and significant socio-economic or other items most important to the profession. In order to do this, he should personally or through contact, be more or less in complete touch with the working of the various and sundry groups which are responsible for the administration of the affairs of the society. This type of editorial has a policy-making bearing whether signed or not. It has been the policy of the present Editor, therefore, since he took office, to make a preliminary preparation of his editorials. About the second or third going over, he sends a mimeographed copy to each member of the Publication Committee and other policy-making officials of the State Medical Society, including the immediate Past President, the President-Elect, the President, the Speaker and Vice Speaker of the House, the Chairman and Vice Chairman of The Council, the Secretary, the Executive Director, the Public Relations officer, the President and Director of Michigan Medical Service and our Attorney.

These men are asked to make corrections or additions, or to suggest other and different editorials. In selecting this advisory group, the Editor knows that a large group of well-posted officials have read his editorials and if they do not comment, they have by acclamation approved them. The final form of the editorials, incorporating any suggested changes, is then made up and sent to the editor.

THE JOURNAL occasionally also uses a guest editorial. Whenever any of our members has an inspiration to write an editorial which he will sign, we are happy to consider it, the restriction being that if it is controversial, we have someone prepare a response to be published simultaneously. That has been done several times in years past.

## Medicine and Legislation

There are many problems which need the attention of our friends in the legislature. The medical profession should grasp every opportunity to accomplish some of them. A compelling fact is that relief agencies, welfare agencies, and the government, notoriously underpay the doctor and the hospital for their services. Many years ago, the Michigan State Medical Society House of Delegates expressed the conviction and belief that patients who are the medical and health responsibility of governmental departments, cease to be indigents. Under the old philosophy, they were "our" responsibility and the medical profession cared for them for nothing or token fees.

The State clothes them, feeds them, gives them shelter, so it should also provide health services. The law sets up some limited rates for hospital payments and payments for doctors which are ridiculously inadequate. Our Michigan State Medical Society House of Delegates in the September 1960 meeting adopted a resolution calling upon the various component county and district medical societies to review the compensation rates with their state, county and local officials and bring them up to date. Until recently one stumbling block has been that the state was broke and didn't have the money, but now two occurrences relieve that situation.

The Kerr-Mills Bill (also called AMA) enacted by the Federal Congress provides a means of taking care of the senior citizens of inadequate income who need assistance through combined state and federal general tax funds. This program is in successful operation. It provides that for local areas, counties, etc., the state and federal combined authority will pay 90 per cent of the local charges, thus relieving the county and local welfare departments of the heavy charges they have complained about. There is now no reason why our county welfare officers should refuse to meet reasonable charges such as those contained in The Fee Schedule for Governmental Agencies, dating back over a period of years and published by the Michigan State Medical Society. The local agency will now pay only 10 per cent of the bill instead of from 50 to 60 per cent as it did up until now.

Also, the Michigan Legislature in its special session acting upon the vote of the people, authorized an increase in the sales tax, thereby putting the state back into the solvency column. The state cannot waste money, but paying the actual cost of hospital beds and services, and a minimum cost for medical and surgical care is a duty and responsibility and not a luxury.

The MSMS House of Delegates urges these conferences with the responsible agencies and officials and

The Council has passed on that information to the various counties. All these county and district societies should act immediately because there are certain provisions in some of the laws by which certain of the state agencies are limited in the amount they may pay for services or accommodations, specifying that they will not pay more than other governmental agencies. For instance, the Crippled Children Commission may not legally pay more for certain services than the welfare commission does in that county or district. This situation is ridiculous but true. Each agency should pay an adequate amount but neither should be limited by what the other may do in any particular area.

## Federal Programs

One of the most important items in the recent political campaign was the care of the aging—the over-65 person who is a beneficiary of the social security program. It was proposed to give them their health services under social security (Forand type plan) and President Kennedy in his campaign, promised he would bring this about. His agitation and his threat to put health services under social security stimulated the so-called Kerr-Mills Bill. This was enacted instead of either the Forand type legislation or the plan advocated by former Vice President Nixon. This Kerr-Mills program is now in operation. It has its imperfections but it can be made to work. It **MUST** be made to work.

At its interim session in Washington, November 27-December 2, the AMA devoted untold hours of study, planning and conferences to evolve a program for the aging (over-65 person) whose income is limited. The most important result was a reconfirmation of the medical profession's belief in and devotion to Blue Shield and Blue Cross type protection. It was expressed repeatedly that such a program, with the co-operation of the AMA and the American Hospital Association, could provide the needed services if only allowed to do so.

All interested personnel must realize that if this essential program fails, and medical care is placed under social security, it will spell the end of the private independent practice of medicine, as we have known it. It has ceased to be a case of waiting until one can make a little change here and another there, with neither going forward toward the grand objective and accomplishing the complete goal. Medicine must first save the basic program, then make such minor or major changes as are needed after the basic program is working efficiently.

The philosophy of let's work now and solve the differences later was almost universally expressed.

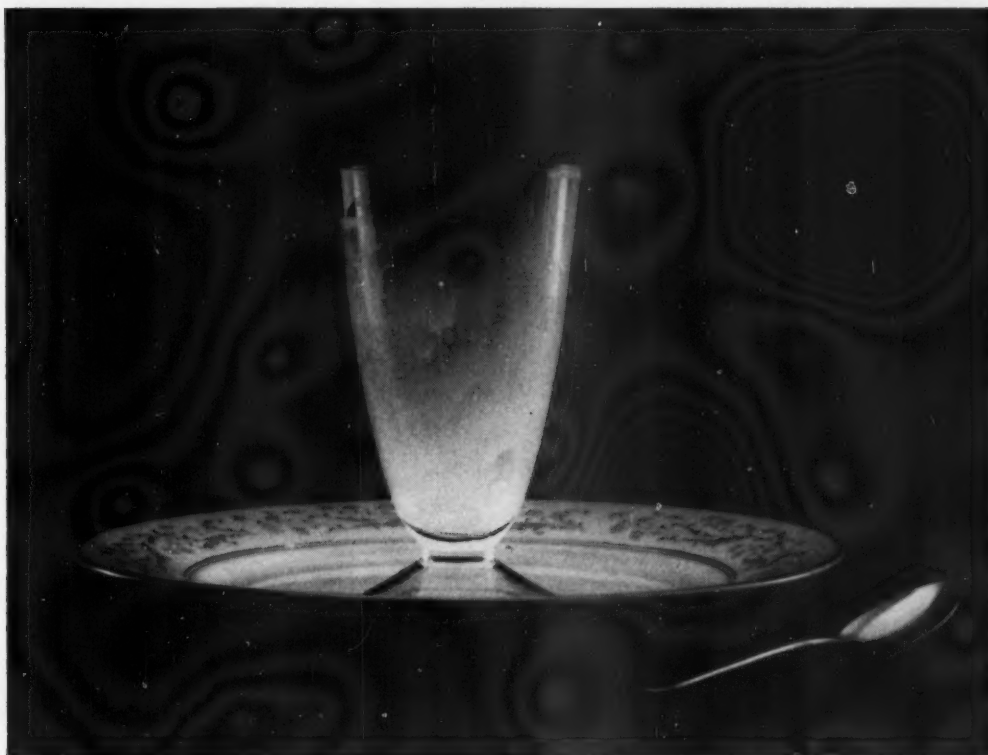
## The McNerney Report

Professor Walter McNerney of the University of Michigan gave a talk on "Medicine and Hospitals in Michigan" at the 1961 Annual County Secretaries, Public Relations Seminar. He devoted his talk much more to hospitals than to medicine, the hospitals being in much more difficulty than the medical profession. He compared the cost of living rate increase based upon the Chamber of Commerce 1948-9 as 100, which has gone up 24 per cent.

He reminded his audience that labor for the restoration and preservation of hospitals has gone up 90 per cent, due to increased costs of wages and salary and to increased usage of many expensive utilities and extension of service rendered. In the medical end, the increase has been 39 per cent *in toto*, due also to the very rapid extension of possible facilities, entering new fields and rendering services unheard of ten years ago. He stated that increased costs for surgery have been 23 per cent against a total cost of living of 24 per cent. When broken down into items, the medical profession has done an acceptable job, comparing the extended services now given with the very limited service of ten years ago.

He mentioned that the medical profession had done a job in making health services available to patients by setting up a program whereby health services are available through a regular contribution. Blue Cross and Blue Shield give subscribers services rather than money. This program is here to stay. It cannot be discontinued because it has grown into the economy and people are now demanding services. Labor is increasing its demand that management take over the premiums for the various insurance programs. More than 70 per cent of the hospital bills in Michigan are now being paid through insurance, Blue Cross, or numerous insurance companies. In medicine, that figure is only 19 per cent, and that service must be extended if the public is to be satisfied.

Caring for these people through the insurance principle is firmly established, and the medical profession which established this principle must see to it that it does not fail else this program will of necessity go to the government. Professor McNerney said that our basic principles are correct, but within our own ranks, we must adjust our minor internal differences of opinion. He said the medical and health professions have the ability and mechanism to provide top quality health services to patients in Michigan by united effort.



## does the bowel take kindly to no-bulk diets?

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Aspirin .....	150 mg.
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<b>ANTIHISTAMINIC</b>	
BRISTAMIN (phenyltoloxamine citrate).....	25 mg.
<b>Dosage:</b> Adults: 2 capsules 3 or 4 times a day for 3 to 5 days.	
Children: 6 to 12 yrs.: One-half the adult dose.	
<b>Supplied:</b> Bottles of 24 and 100 capsules.	

According to a report by the Council on Drugs of the American Medical Association,\* antibiotics may be administered for prophylaxis against secondary bacterial invaders in the following types of patients with influenza: pregnant women; debilitated infants; older individuals; patients being treated for other bacterial infections with chemotherapeutic agents, and patients with chronic, nonallergic respiratory disease.

\*Council on Drugs, J.A.M.A. 165:58 (Sept. 7) 1957.

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## Ribicoff Directs HEW

Abraham Ribicoff, former governor of Connecticut, is the new Secretary of Health, Education and Welfare, appointed by President Kennedy to succeed Arthur S. Flemming.

The 50-year-old governor, an early supporter of Kennedy for the nomination, made a national reputation for inaugurating a comprehensive traffic safety program with strong penalties.

A graduate of the University of Chicago law school, Secretary Ribicoff has served as a Hartford, Conn., police judge, a member of the state legislature, a member of Congress. He was elected governor twice.

Mr. Ribicoff was one of 23 governors who signed a telegram to the Senate Finance Committee last session urging enactment of a Social Security health care program for the elderly.

As HEW Secretary, Mr. Ribicoff will be the cabinet officer responsible for most of the Federal activities that involve the medical profession and public health, including the U. S. Public Health Service, the National Institutes of Health, the Social Security Administration, Food and Drug Administration, Office of Education, and Office of Vocational Rehabilitation.

Some \$15 BILLION annually is distributed by HEW, with a large share being Social Security payments. The PHS budget is about \$1 billion.

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### Doctors Serving Peace

The first team of medical volunteers is serving aboard the *Hope 1* in Indonesia—serving on the front lines of peace in the new Project HOPE. Many others are all set to work their shifts and there is a waiting list of over 20 American doctors of medicine who have volunteered to serve.

Project HOPE is advancing plans now for similar projects for Africa and South America.

\* \* \*

### Doctor Bauer Named Consultant

Louis H. Bauer, M.D., former secretary-general of The World Medical Association, is a consultant now to that organization. A past president of the American Medical Association, he was secretary general from 1948 to 1960.

Heinz Lord, M.D., of Barnesville, Ohio, is the new secretary-general of The World Medical Association.

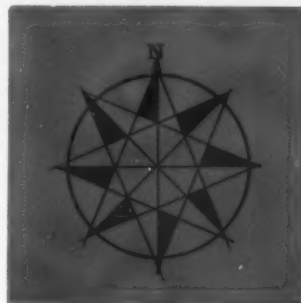
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### Directs AMA Council on Drugs

The American Medical Association has selected William C. Spring, Jr., M.D., Brooklyn, N. Y., as the new secretary of its Council on Drugs.

Dr. Spring, who holds degrees from Wisconsin, Duke, and Columbia universities, succeeds Harold D. Kautz, M.D., who resigned to accept a position with Abbott Laboratories, North Chicago, Illinois.

Dr. Spring comes to the AMA from Chas. Pfizer & Co., Brooklyn, where he had been serving as medical director of the laboratories division.



NATIONAL  
AND WORLD

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## Berlin Industries Fair

By PHILIP BOCKMAN

Of the 600,000 people who saw the 1960 Berlin Industries Fair in Germany, about 500,000 went through the United States exhibit. There they saw twenty-seven American teens and about thirty sons and daughters of U. S. Army personnel stationed in Berlin, all engaged in some type of "typical" American activity. There were girls modelling teen fashions, boys with "hot-rods" and go-carts, Boy Scouts with flapjacks, boys on the tumbling mat, girls displaying samples of American books, and people with exhibits of electronics, mathematics, space science, chemistry and medicine.

My exhibit, consisting of pictures and an x-ray, showed how I replaced a dog's Achilles tendon with an artificial tendon of stainless steel wire and polyethylene tubing and Ivolon. The Germans posed many questions about American medicine, medical schools, and research. Evidently their students, in medical school, must wait until nearly the end of their schooling to engage in work with live animals. In America our education is more clinical in nature.

Other scientific exhibits included an ultraviolet flying-spot electron microscope, a space-unit for survival on Mars, and a discovery of the effect of testosterone on the production of red blood cells—all

demonstrated by the teenagers who made them.

We were in Berlin four and one-half weeks, working at the Fair nearly three weeks. We met Mayor Brandt and the Bundes President and many prominent German scientists, and they questioned us about all phases of American life. During the two weeks of the Fair's opening to the public, we had only a few heckling visitors; everyone was pleasant and interested. Some of us were invited to private homes in Berlin, and again we found the German people friendly and hospitable.

We returned to the U.S.A. with mixed feelings of hating to leave Germany and being very glad to be home. On behalf of all twenty-seven of us, I hope that we have created a favorable image of the United States—in medicine and other fields—in the minds of the German people.

\* \* \*

Philip Bockman is the young man from Grand Rapids who won the National Science Award last spring for his work on replacing a dog's Achilles tendon by an artificial tendon of steel and polyethylene tubing. He received a \$1,000 check from the American Academy of General Practice to help him attend the World Youth Congress in West Berlin. He is now a freshman medical student at the University of Michigan.

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With the Thrombitron, all the required test components are within finger tip reach. The entire test

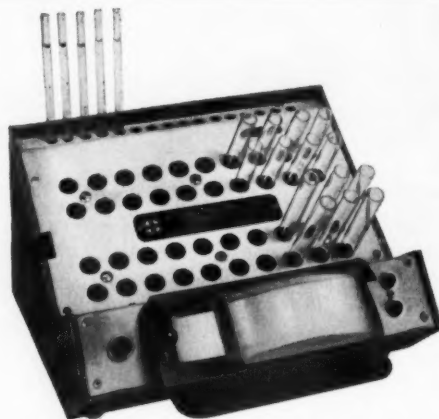
can be performed with the technologist seated at the lab table—no wasted time or motion.

Unit is designed for either accepted standard method—"tilt" or "loop." A constant light source and magnifying viewer assure accurate observation. The Adams Thrombitron has no moving part or complex electrical circuits—no maintenance problems.

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# Elect New Leaders For Health Council

Sidney E. Chapin, M.D., Dearborn, assumed the presidency of the Michigan Health Council at the organization's recent annual meeting in Detroit. Officers and members of the Board of Trustees also were elected at the meeting, which was held in McGregor Memorial Conference Center.

William McNary, Detroit, executive vice president and general manager of Michigan Hospital Service, was named president-elect. Marvin L. Niehuss, vice president and dean of faculties of the University of Michigan, is the retiring president. Hugh W. Brenneman, MSMS public relations counsel, was re-elected secretary. L. Gordon Goodrich, executive vice president of Michigan Medical Service, was elected to succeed himself as treasurer. J. K. Altland, M.D., Lansing, was elected medical director and Harry B. Zemmer, M.D., Lapeer, continues as president emeritus.

Those re-elected to three-year terms as members of the Board of Trustees were Otto K. Engelke, M.D., Ann Arbor, MSMS president-elect; James H. Fyvie, M.D., Manistique; Mrs. Marjorie Karker, Lansing, Farm Bureau Women's Activities; Mrs. Grace Kistler, Grand Haven; Gordon H. Scott, Dean of Wayne State University College of Medicine; E. Gifford Upjohn, M.D., president, Upjohn Company; and Mr. Niehuss.

Twelve new member organizations and two new Associates joined the Health Council and received certificates at the Council's Annual Meeting December 8.

New voting members were: American Cancer Society, Southeastern Michigan Division; Alma College; Eastern Michigan University; Gerber Baby Foods Fund; Hope College; Michigan Association for Emotionally Disturbed Children; Michigan Cancer Foundation; Michigan Dietetic Association; Michigan Elks Association, Major Project Commission; Michigan Society of Gerontology; Wayne State University College of Pharmacy; and Western Michigan University. Organizations accepted as Associates were Ira Wilson & Sons Dairy Company and Mallard, Inc.

With the addition of these 12 voting members, the membership of the Health Council now stands at 93. There are seven Associates.

\* \* \*

## Heads Cancer Foundation

Rosser L. Mainwaring, M.D., of Dearborn, is the new president of the Michigan Cancer Foundation. He succeeds Howard P. Doub, M.D., Detroit.

Appointed as chairman of the Foundation's medical and scientific committee is Oscar D. Stryker, M.D., newly-elected vice-president and director of the Macomb County Health Department. Newly-elected trustees are Brock E. Brush, M.D., Dearborn; Joseph A. Witter, M.D., Highland Park; Gordon R. Maitland, M.D., Detroit; Gerald S. Wilson, M.D., Detroit, and Glenn W. Bylsma, M.D., Pontiac.



ANCILLARY

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Other officers were re-elected, including Lyndle R. Martin, M.D., Detroit, as secretary.

Michael Boris Shimkin, M.D., Associate Director of the National Cancer Institute, was guest speaker at the dinner which followed the annual board meeting. He spoke on "International Aspects of Cancer Research."

### *Join MAP Meeting at Saginaw*

Many doctors in the Saginaw area participated in the meeting sponsored recently by the Michigan Association of the Professions at the Rolling Green Country Club, Saginaw.

V. E. Cortopassi, M.D., was a member of the local committee which brought together more than 100 men in the professions of architecture, dentistry, engineering, medicine, law, pharmacy, and veterinary medicine, to exchange ideas on programs to advance professional ideals and interests and to learn more about the structure, projects and goals of MAP.

### *Plan Accreditation of Nursing Homes*

Delegates to the American Nursing Home Association convention in Washington adopted a resolution that gives the green light to one of its special committees to work out the details of a plan for accreditation of nursing homes.

Calling for several levels of supervision, the ANHA accreditation program would be set up on a nationwide basis.

"My committee is ready with a program consistent with the progress our American Nursing Home Association has made," declares Elmer Kocovsky, M.D., committee chairman and president of the Wisconsin Nursing Home Association. "The demand from our membership is so great that it is imperative that we start on a program immediately."

In advocating an ANHA accreditation program,

Dr. Kocovsky made it clear that its creation does not indicate any lack of interest in plans of the Tripartite Committee on Accreditation, consisting of representatives of ANHA, The American Hospital Association and American Medical Association.

### *Association of Blood Banks Holds Detroit Conference*

The Michigan Association of Blood Banks held its annual meeting recently in Detroit. A comprehensive workshop in blood banking was held at Wayne State University Medical College while the scientific program was conducted at the David Whitney House. Numerous excellent speakers were included in the scientific program. This meeting was a part of the Continuing Education Program of the Michigan Association of Blood Banks which helps medical technologists and pathologists keep up on the latest developments in blood banking.

### *Invite Doctors to Attend Chamber Aircade in Detroit*

The United States Chamber of Commerce "Aircade for Citizenship Action" will stop in Detroit March 1 to present a program—and Michigan doctors of medicine are invited to attend.

Doctors are encouraged to contact their local chambers of commerce, which are arranging motorcades and chartered buses to the Detroit meeting.

The Detroit program will begin at 9:25 a.m. at the Masonic Temple and will conclude at 3:30 p.m. The session will specifically cover medical care for the aged and other timely topics.

Arthur H. Motley, president of the U. S. Chamber and publisher of *Parade Magazine*, will head the Aircade team.

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# Obstetrical BREVETS



(This column is sponsored by the Michigan Society of Obstetrics and Gynecology)

## Evaluation of Maternal Deaths Due to Direct Obstetric Causes

Michigan, 1950-57\*

In the Michigan Maternal Mortality Study all maternal deaths are evaluated by the Central Evaluation Subcommittee of the Maternal Health Committee of the Michigan State Medical Society. This committee consists of the chairmen of the Departments of Obstetrics and Gynecology of the University of Michigan and of Wayne State University, the chairman of the MSMS Maternal Health Committee and the obstetric consultant of the Michigan Department of Health. Regional evaluation subcommittees have been established in Saginaw, Grand Rapids, Kalamazoo, and Lansing.

classified as due to a direct obstetric cause, to an indirect obstetric cause, or to an unrelated cause. A death due to a direct obstetric cause is one clearly resulting from the pregnancy, as in hemorrhage, toxemia, infection, transfusion reactions, et cetera. A death due to an indirect obstetric cause is one in which the death was caused by some condition other than the pregnancy but which could have been aggravated by the pregnancy, e.g., cardiac, vascular, reproductive, tract, hepatic, pulmonary and metabolic diseases and others, such as appendicitis and sickle cell disease. Example of non-related causes are cancer, accidents, et cetera.

An effort is then made to decide whether factors of preventability were involved. It is attempted to be completely objective in this analysis and conclu-

TABLE I. MICHIGAN MATERNAL MORTALITY STUDY, 1950-1957  
(Preventable Factors)

	Physician	Consultant	Patient	Physician and Patient	Physician and Consultant	Physician and Hospital	Physician Patient and Hospital	Hospital	Unpreventable
Abortion	3	0	41	0	1	0	1	0	0
Ectopic pregnancy	23	0	8	7	1	2	0	0	7
Placenta previa	12	0	0	0	3	1	2	1	4
Abruptio	9	0	2	0	2	2	0	0	8
Placenta accreta	0	0	0	0	0	0	0	0	2
Inversion uterus	3	0	0	0	0	0	0	0	0
Rupture uterus	55	0	0	3	7	2	0	0	5
Postpartum hemorrhage	42	0	2	2	2	5	0	1	11
Toxemia	51	2	12	26	1	1	0	0	28
Septicemia and peritonitis	19	1	3	0	2	4	0	0	9
Amniotic fluid embolism	0	0	1	0	0	0	0	0	1
Air embolism	0	0	0	0	0	0	0	0	7
Anesthesia	32	0	0	0	0	2	0	0	14
Afibrinogenemia	1	0	0	0	1	0	0	2	7
Transfusion misadventure	5	0	1	0	0	5	0	5	0
Total	255	3	79	38	20	24	3	9	110 = 44%

In the evaluation of maternal deaths, the Central Evaluation Subcommittee attempts to ascertain the cause of deaths by considering the clinical course of the case, the information provided on the death certificate, and the findings at postmortem examination, when these are available. The cause of death is then

\*Maternal deaths due to indirect obstetric causes will be discussed in a subsequent article.

sions are reached without a knowledge of the area or hospital in which the death occurred, the name of the patient, or of the physicians in attendance. The data is studied to determine what factors may have contributed to the death of the patient—whether she failed to cooperate, or if there was an error in medical skill or judgment, or whether the hospital facilities (including laboratory services, nursing care or equipment), were inadequate. This is not to say that

the patient necessarily would have survived had these factors not been present.

Of the 987 maternal deaths in 1950 through 1957, 624 were due to direct obstetric causes, 252 to indirect obstetric causes and 111 to non-related causes. Of the 624 deaths due to direct obstetric causes, 110 were considered unpreventable. Preventable factors were found in the remaining 514 cases (Table I).

Medical factors alone were concerned in 278 cases. Patient factors, usually consisting of neglect to obtain prenatal care or submitting to criminal or self-induced abortion, or failure to follow medical advice, were present 79 times. Medical and patient factors were involved jointly 38 times; the physician and the hospital 24 times; the hospital 9 times; and the physician, patient and hospital 3 times.

Medical factors occurred most frequently in deaths from ectopic pregnancy, placenta previa, rupture of the uterus and postpartum hemorrhage, all classified as Hemorrhage. We are particularly concerned with this finding. In spite of the high rate of preventability, deaths from hemorrhage increased in the 1954 through 1957 period to 1.89 per 10,000 live births as compared with 1.70 per 10,000 live births in the years 1950 through 1953. The preventable factors were usually: deferring examination of patients with ectopic gestations until the bleeding ceased or postponing oper-

ation after making the correct diagnosis to await improvement in the condition of the patient; examination (vaginal or rectal) of patients with placenta previa without preparation for transfusion and immediate cesarean section; rupture of the uterus after prolonged labors in grand multipara with malpresentations or traumatic deliveries (version and extraction or difficult forceps procedures) through an incompletely dilated cervix, or the antepartum or intrapartum administration of pitocin without regard for contraindications or the observance of all requisites.

In 26 deaths from toxemia, the patient had failed to seek prenatal care and in many of these instances was already eclamptic when admitted to the hospital. Where medical responsibility was involved, it was usually due to failure to hospitalize patients with signs of impending toxemia, or induction of labor before the patient had been stabilized.

Maternal mortality in Michigan will be reduced by:

1. Early and regular prenatal care, which should be started as soon as pregnancy is suspected.
2. Examining all patients at the first prenatal visit regardless of bleeding.
3. Early consultation in all complicated cases.
4. Prompt operation while replacing lost blood after ectopic pregnancy is recognized.
5. Avoiding vaginal or rectal examinations until preparations for cesarean section have been made and blood is made available in painless bleeding in the last trimester.
6. Replacing lost blood in abruptio placenta and checking fibrinogen concentration, and unless indications of early vaginal delivery are present, delivering abdominally.
7. Avoiding version and extraction except for the second twin. Using forceps as a trial procedure.
8. Restricting antenatal pitocin administration to carefully selected patients and observing all contraindications and requisites.
9. Re-evaluating all cases of prolonged labor by x-ray examination and consultation.
10. Having compatible blood available for every delivery.
11. Exploring the pelvis when bleeding is excessive.
12. Hospitalizing and stabilizing patients with toxemia.

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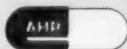
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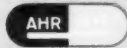
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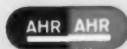
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In each capsule: Phenacetin (3 gr.) 194.0 mg.; acetylsalicylic acid (2½ gr.) 162.0 mg.; hyoscyamine sulfate 0.031 mg.; and phenobarbital (¼ gr.) 16.2 mg.



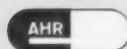
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To each "according to his need" — maximum safe analgesia through time-and-pain-tested synergistic formulations, in four strengths for individualized prescription.

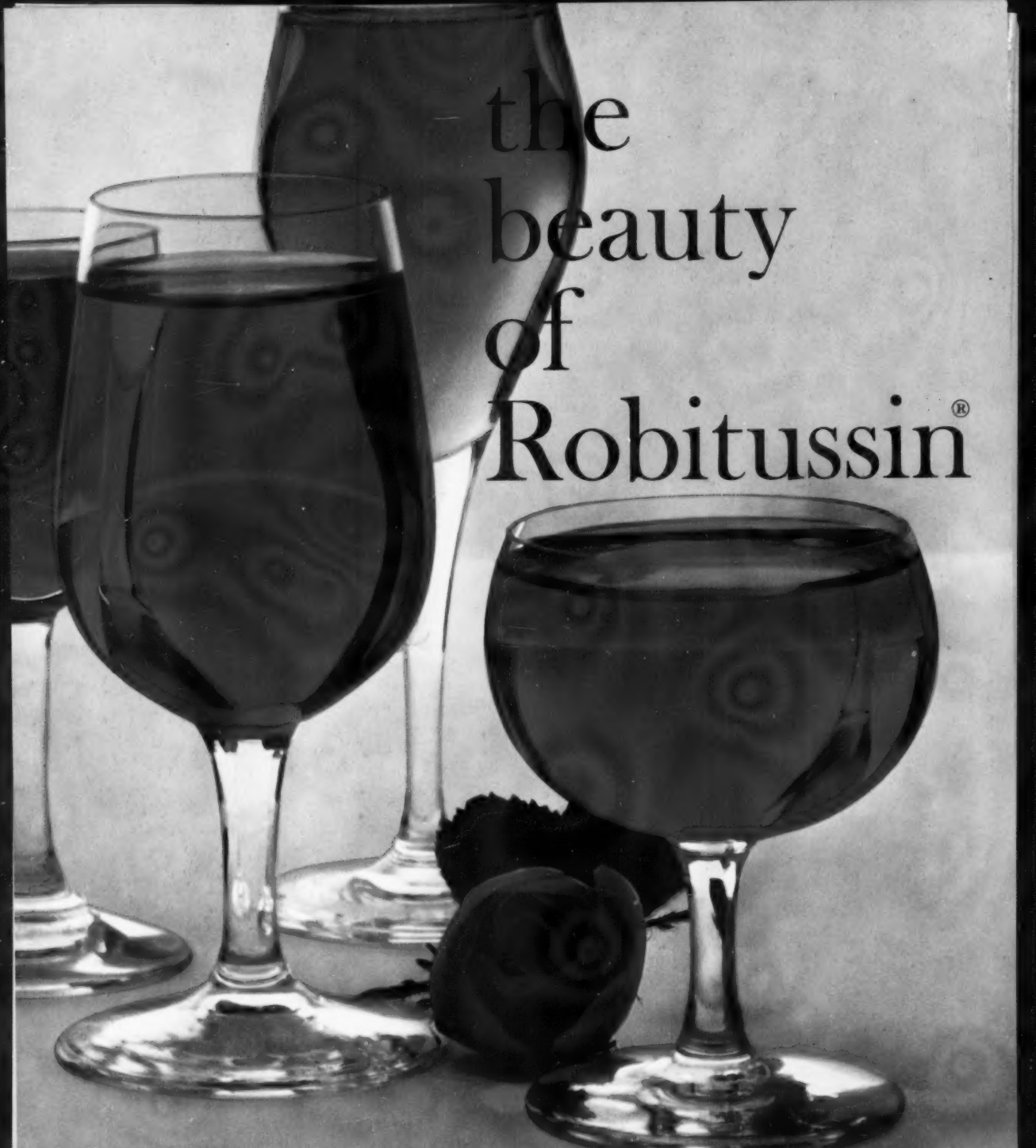
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## MICHIGAN DEPARTMENT OF HEALTH

ALBERT E. HEUSTIS M.D., State Health Commissioner

### Highlights 1960—Part Two

Last month, we highlighted some of the laboratory services of the department. This month, we review some of the activities in the field of mass screening examinations.

As we have said before in these pages, we know that the early detection of many diseases can and does save lives and prevent serious disability. Therefore, we believe there is a vital need to use the proven early detection weapons we have on a much larger scale. Such screening programs are aimed at getting the person with possible disease to his physician for diagnosis as soon as possible, when the chances for correcting or alleviating the condition are best.

During the past year, a number of screening programs were conducted to detect possible tuberculosis, heart disease, cancer, venereal disease, glaucoma and diabetes.

#### Tuberculin Skin Testing

More than 442,000 persons were screened with the Mantoux test in 42 counties. This was an increase of 51 per cent over those tested last year. About 94 per cent of those tested were school children. Among these children, 1.3 per cent were reactors as compared with 1.7 per cent in the approximately 280,000 tested last year.

#### Chest X-ray

A total of 292,102 chest x-ray screening films was taken in surveys in 57 counties. Of these, 12,598 showed some chest abnormality; 4,265 showed suspected tuberculosis, including 1,367 active or probably active; 4,173 showed suspected heart disease; 481 showed suspected lung cancer; and 3,782 showed other chest pathology.

In addition, 6,947 follow-up 14 x 17 x-ray films were taken in 37 counties.

#### Diabetes

Diabetes continues to be the sixth leading cause of death in Michigan, taking 1,715 lives in 1959. It is also the third leading cause of blindness. Over 26,500 persons were screened for diabetes in 1960, with 313 revealed as diabetes suspects. Diagnostic returns are

not complete, but so far 89 new cases have been diagnosed, 22 old cases brought under supervision, and 22 diagnosed as not presently diabetic but with regular checkups advised. Five new Glover-Edwards Diabetes Test Kits were secured late in the year and are now being set up in five areas in the state where small scale regular diabetes screening operations will be carried on.

#### Cancer

Over 4,000 women were examined for possible cervical cancer in screening programs. While diagnostic findings are not yet in for all the women who were found to be cancer suspects, 15 cases have been definitely diagnosed. These preliminary findings give a rate of 2.8 cancer cases per 1,000 examinations.

#### Glaucoma

In two counties, 2,044 persons were screened for glaucoma, the second leading cause of blindness. Of these, 61 had a positive test and 10 were diagnosed as glaucoma. No glaucoma was the diagnosis in 23, 15 others were questionable and being followed by ophthalmologists. The remaining 13 had not had all tests needed to make a diagnosis.

#### Venereal Disease

Reported cases of primary and secondary syphilis in Michigan showed a decided jump. There were 146 cases in 1959-60 compared to 79 cases in 1958-59, or an increase of 85 per cent.

During the year there were 33,469 blood tests for syphilis done in surveys. As a result, 344 persons were either brought to, or returned to, treatment. Clinics throughout the state carried out 21,442 diagnostic observations for venereal disease and 8,663 persons were treated.

#### New Address

As of December, the staff and offices of the Division of Hospital and Medical Facilities have moved from their previous location in the Bauch Building, Lansing, to the first floor of the Administration Building of the Michigan Department of Health, Old DeWitt Road, Lansing 4, Michigan.

*Available only to physicians for their distribution—*

# Complete Cholesterol Depressant Menus and Recipe Book

A new, authoritative patient-aid . . . for professional distribution only

*Now available for use in your practice from The Wesson People . . . easy-to-use manual of 40 pages, including all necessary diet instructions . . . menus, recipes, shopping and cooking guidance . . . all worked out for you . . . so arranged and printed that you have only to check the desired daily calorie level before giving the book to your patient.*

You will find this book invaluable for treating patients with elevated serum cholesterol.

**Complete menus for 10 days** enable you to prescribe diets which are appetizing, nutritiously adequate and which can exert cholesterol depressant activity. Special attention has been given to constructing the menu patterns so that they adhere as closely as permissible to the patient's normal eating habits.

**NRC Standards fulfilled.** Each menu has been calculated to provide the proper daily allowance of proteins, vitamins and other nutrients as recommended by the Food and Nutrition Board of the National Research Council.

**Weight control is achieved** as each day's menu is given at 3 calorie levels—1200, 1800 and 2600 calories. You prescribe the level most desirable and modify as desired.

**Variety and appetite appeal for patient** are built into the menu plan to an extent not previously accomplished. Alternate choices for main dishes minimize monotony, encourage the patient to follow closely the menu plan you specify.

**Complete recipes—65 in all—**are included to assure that the specified menus provide prescribed levels of calories, the pre-determined ratio of poly-unsaturated to saturated fat, plus essential nutrients.

**Dietary fat is controlled** so that approximately 36% of the total calories are derived from fat and at least 40% of these fat calories are from poly-unsaturated components (linoleates) as found in pure vegetable oil. The replacement of saturated dietary fat by this percentage of poly-unsaturated fat has been found in clinical studies most effective in the reduction of serum cholesterol and in its maintenance at desirable levels. More liberal menus are provided for maintenance after the patient's progress indicates that desired therapeutic results have been accomplished.

**Family meal preparation is simplified.** The menus are planned around favorite foods having wide appetite appeal for all members of the household. Patients can entertain in comfort—enjoy cakes, cookies, snacks, prepared with recipes which meet medical requirements.

**A high degree of satiety is achieved** even at the lower calorie levels, because Wesson provides an unexcelled source of concentrated, slow-burning food energy.

**Adaptable for use with diabetics.** Carbohydrates have been calculated to fall within the acceptable range for patients to whom a diet planned for diabetes is important. Calories, which must be supplied from fat when the carbohydrate intake is limited, are provided by desirable poly-unsaturated vegetable oil.

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Linoleic acid glycerides (poly-unsaturated) . . . . .	50-55%
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Palmitic, stearic and myristic glycerides (saturated) . . . . .	25-30%
Phytosterol (Predominantly beta sitosterol) . . . . .	0.3-0.5%
Total tocopherols . . . . .	0.09-0.12%
Never hydrogenated—completely salt free	

*Poly-unsaturated Wesson is unsurpassed by any readily  
available brand, where a vegetable (salad) oil is medically recommended  
for a cholesterol depressant regimen.*

# Your Cholesterol Depressant Diet Book

Menu plan for

Mrs. John Doe  
DATE Feb. 1961

JOSEPH ROE

M.D.



**STRICTEST CONTROL**

**breakfast**

**lunch**

**snack**

**dinner**

**snack**

**menu 1**

**lunch substitution**

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Each tablet contains:

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*Neo-Synephrine® 10 mg.*—to shrink nasal membranes and open sinus ostia

*Acetylsalicylic acid 300 mg. (5 grains)*—to reduce fever and relieve aching

*Chlorpheniramine maleate 2 mg.*—an antihistamine to shrink engorged membranes and lessen rhinorrhea

*Ascorbic acid (vitamin C) 50 mg.*—to increase resistance to infections†

New Win-Codin tablets will bring more comfort to many patients suffering from severe colds, influenza or sinusitis.

*Average dose:* Adults, 1 or 2 tablets three times daily; children 6 to 12 years, from ½ to 1 tablet three times daily.

Available in bottles of 100 (Class B narcotic).

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## Brief and to the Point

**FLINT SURGEONS ELECT**—The Flint Academy of Surgery, at its annual meeting, installed Harold W. Woughter, M.D., as president for 1961 and named Donald R. Wright, M.D., as president-elect. Also elected were Richard L. Rapport, M.D., secretary-treasurer, and Russell C. Sandberg, M.D., corresponding secretary. Dr. Woughter succeeds William P. Boles, M.D.

\* \* \*

**ADVISORS HONORED**—Three veteran medical advisors of Dickinson County were recognized for their long service to the Dickinson Selective Service board at a meeting of the Iron Mountain Rotary Club. Honored were W. H. Alexander, M.D., W. H. Huron, M.D., and D. R. Smith, M.D.

\* \* \*

**APPRECIATION VOICED**—The Ottawa County Selective Service presented pins and certificates of appreciation for 20 years of service to the draft board by three Ottawa doctors of medicine. Honored were Edwin Vander Berg, M.D., and H. J. DeVries, M.D., both of Holland and C. E. Boone, M.D., Zeeland.

\* \* \*

**HONORED BY STATE HEALTH OFFICERS**—John D. Monroe, M.D., director of the Oakland County Department of Health, was presented with a distinguished service award by the Michigan Health Officers Association.

Formal presentation of the award was made during the December 2 meeting of the Oakland County Board of Supervisors.

In point of service, Dr. Monroe has been a health officer longer than any other Michigan health officer. He has served since Dec. 31, 1926.

He was instrumental in organizing the Oakland County Department of Health, the first in Michigan. Now 65 of the 83 counties are served by health departments.

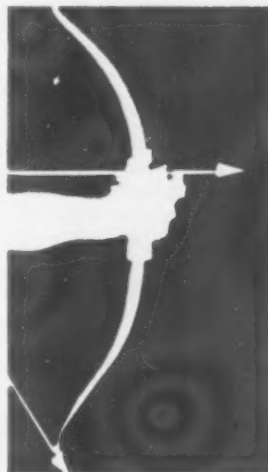
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**RECEIVES GRANT**—Seventeen research grants of the Tobacco Industry Research Committee includes one to Edward F. Domino, M.D., Ann Arbor. He is studying the "Effects of tobacco smoke and nicotine on the central nervous system." The Committee made 57 grants to scientists in 1960 for a total of nearly \$800,000.

\* \* \*

**EXAMS SOON**—The American Board of Obstetrics and Gynecology will conduct oral and clinical examinations (Part II) at the Edgewater Beach Hotel, Chicago, April 8 through 15. Current Bulletins of the American Board of Obstetrics and Gynecology, outlining the requirements for application, may be obtained by writing to Robert L. Faulkner, M.D., Secretary, 2105 Adelbert Road, Cleveland 6, Ohio.

Contributions for this "News Brief" department are invited from individual physicians, from county societies, and from other health organizations. Please direct your contributions to the Editor.



NEWS BRIEFS

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#### NEWS BRIEFS

**ENDS PUBLICATION**—*The Armed Forces Medical Journal* with the December 1960 issue ceased publication. It has been published for 11 years, representing the three branches of the Department of Defense and printed in the United States Government printing office. There has been no advertising. It has been an excellent medical journal with a few short editorial comments. It is hoped much of this material will appear in *Military Medicine*, published by the Association of Military Surgeons.

**STARTS PUBLICATION**—*The Journal of Surgical Research*, a new medical journal, is announced by the W. B. Saunders Company.

*The Journal of Surgical Research* will carry no advertising, will have no set size, and will appear early in 1961, possibly May.

Michigan is especially interested because the editor will be Charles G. Child III, M.D., Ann Arbor, and the Assistant Editor is George D. Zuidema, M.D., also of Ann Arbor.

**SOCIETY ELECTS**—Officers of the Western Michigan Pediatric Society for 1960-1961 are as follows: president, S. Sprigg Jacob, M.D., East Lansing; vice president, Jerome E. Webber, M.D., Grand Rapids; secretary-treasurer, Marshall J. Feeley, M.D., St. Joseph; assistant secretary-treasurer, John L. Doyle, M.D., Grand Rapids.

**REPORTS EXPENDITURES**—Figures provided by the National Foundation for campaign efforts during the past 23

years in Michigan reveals that \$18,125,791 have been available to Michigan county chapters, and grants of \$4,066,908 have been made to Michigan institutions for research and educational projects. Funds also have been spent, according to the report, for vaccine field trials, salk vaccine and gamma globulin.

**U-M COURSES**—Several postgraduate courses are on the calendar at the University of Michigan during the next several months. Slated for the U-M Medical Center are Psychiatry, February 20-21, Electrocardiographic Diagnosis, March 27-April 1, Diagnostic Radiology, April 3-5, and Endocrinology and Metabolism, April 17-21, 1961.

**MEDICAL TELEVISION SHOWS**—The Michigan Health Council reports that the following topics were covered during the month of December on the weekly Sunday morning program over WJBK-TV, Detroit: Cerebral Palsy, rehabilitation, automobile safety and safe winter driving.

**RECEIVES AWARD**—Emilie Gleason Sargent, executive secretary of the Visiting Nurse Association of Detroit, received the University of Michigan "Outstanding Achievement Award" recently. The Award, first given to a woman since its inception in 1958, recognized Miss Sargent's outstanding achievements in the field of health and nursing education. Miss Sargent also received the 1960 Pearl McIver Public Health Nurse Award of the American Nursing Association.

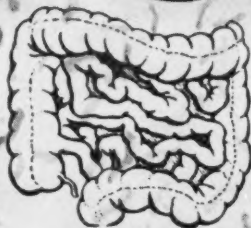
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## NEWS BRIEFS

**ST. MARY'S GRAND ROUNDS**—Saint Mary's Hospital of Grand Rapids held a Grand Rounds program December 1, 1960 at the Pantlind Hotel. The participants were John Bamber Hickham, M.D., Indianapolis; John F. McDonald, M.D., Detroit; Carl A. Moyer, M.D., St. Louis; and Harold O. Peterson, M.D., Minneapolis. The general topics were "Biliary Tract Disease" and "Gastrointestinal Bleeding."

\* \* \*

**NEW PROFESSOR**—David Hywell Davies, M.D., of London, England, has been appointed assistant professor in the department of medicine at Wayne State University College of Medicine. Dr. Davies, whose major research area is cardiology, was on the teaching staff of the National Heart Hospital and Institute of Cardiology in London.

He is a graduate of Oxford, receiving his medical degree in 1952.

\* \* \*

**ELECTED**—Chosen by his fellow physicians, Josef S. Rozan, M.D., of Lansing, is the new chief of staff at the Edward W. Sparrow Hospital. He succeeds F. Mansel Dunn, M.D. Other new Sparrow staff officers are Philip F. Lange, M.D., vice-chief, and S. P. Fortino, M.D., secretary-treasurer.

\* \* \*

**HEADS CORNELL PROJECT**—Robert A. Wolf is the new director of the Cornell University Automotive Crash Injury Research program. Mr. Wolf was a member of the technical staff of Cornell Aeronautical Laboratory, Inc., Buffalo, New York. This new arrangement will facilitate closer

coordination between the Cornell Automotive Crash Injury Research program and Cornell Aeronautical Laboratory, both of which have been engaged in different phases of automotive safety research for many years. Mr. Wolf holds his Masters Degree in Aeronautical Engineering from the University of Michigan.

MSMS is one of the medical organizations cooperating with Cornell in its studies.

\* \* \*

**RETIRES**—Ralph G. Sickels, advertising-public relations executive for Parke, Davis & Company, has retired after 40 years' service. He is 68.

As advertising director, he launched the institutional advertising campaign in national magazines in 1928, which is continuing.

In 1957, the American Medical Association awarded Parke-Davis a citation for "the service it has performed to the public and the nation through its continuing series of institutional messages published in national magazines which accurately and dramatically tell the story of medicine and medical progress."

\* \* \*

**APPOINTED**—Allen W. Byrnes, M.D., formerly with the Veterans Administration hospital at Battle Creek, has been named manager of the VA hospital at Knoxville, Iowa. Dr. Byrnes received his medical degree from Iowa State University and has been with the Veterans Administration since 1940.

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**HONORED**—Howard P. Doub, M.D., (left), Detroit radiologist, receives a silver tray commemorating 20 years as Editor of the journal *Radiology* from T. J. Wachowski, M.D., Chicago, president of the Radiological Society of North America. The engraving on the tray noted: "To Howard P. Doub, M.D., in appreciation of 20 years loyal service as Editor of *Radiology*."

Dr. Doub is consultant in radiology to Henry Ford Hospital in Detroit, where he had served for many years prior to his recent retirement as director of radiology. He received his medical degree from Johns Hopkins University in Baltimore, Md.

\* \* \*

**ON DIABETES PROGRAM**—Jerome W. Conn, M.D., Ann Arbor, discussed "A Concept of the Diabetogenic Period in Man with Study of One Parameter" at the Ninth Postgraduate Course on Diabetes and Basic Metabolic Problems at the Louisiana State University of Medicine in January.

\* \* \*

**HELPS CANCER SEARCH**—A Colostomy Clinic has been established at the Cancer Center, 4811 John R., Detroit, sponsored by the Michigan Cancer Foundation. The Clinic is under the direction of Norman D. Nigro, M.D., Clinical Assistant Professor of Surgery, Wayne State University College of Medicine.

The clinic, established by the cancer foundation with the approval of the Michigan Proctologic Society, is designed to rehabilitate cancer patients having undergone colostomies through professional instruction in proper control and management.

\* \* \*

**RESEARCH GRANTS**—The University of Michigan ranks fifth nationally in the dollar value of research grants from the National Institute of Health. During fiscal 1960, the U-M received a total of \$4,144,910 to support 192 research projects. This figure was topped only by the Uni-

JMSMS

## NEWS BRIEFS

versity of California, Harvard University, New York University, and Johns Hopkins University.

**OFFER NEUROLOGY COURSE**—The American Academy of Neurology will hold its thirteenth annual meeting at the Sheraton-Cadillac Hotel in Detroit, Michigan, April 24-29.

In order to aid the practicing physicians of the region to keep abreast with the new advances in neurology, a review course in the more common neurologic disorders will be offered on Wednesday, April 26. Credit for attendance at this course will be given by the American Academy of General Practice in Category A, 8 hours. The faculty will consist of some of the foremost neurologists of the country. This course will cover some of the more common neurologic disturbances that the physician meets in his practice.

The subjects to be covered are: The Elicitation and Interpretation of Early Signs of Nervous System Disease; Headache—Diagnosis and Management; Strokes—Natural History and Recent Trends in Treatment; Epilepsy; The Neurology of Aging, including Parkinson's Disease; Neurological Complications of Pregnancy; Common Disorders of Muscle, and The Paraplegic States, including Heredodegenerative Disorders.

Other review courses are being offered from April 24-26. The chairman of each of these courses is an outstanding member in the field of neurology. A brochure describing the courses and application blanks may be obtained from Special Courses, American Academy of Neurology, 4307 East 50th Street, Minneapolis 17, Minnesota.

## MEDICAL MEETINGS USA

American College of Surgeons, Sectional Meetings for Surgeons and Graduate Nurses, March 6-9, 1961, Hotels Bellevue-Stratford, Ben Franklin, and Sylvania, Philadelphia, Pa. William E. Adams, M.D., 40 E. Erie St., Chicago 11, Secretary.

American College of Allergists, March 12-17, 1961, Statler Hilton Hotel, Dallas, Texas. Howard G. Rapaport, M.D., 16 E. 79th St., New York City, Secretary.

National Health Council, National Health Forum, "Health and Communication," March 13-16, 1961, Waldorf-Astoria Hotel, New York City. Mr. Philip E. Ryan, 1790 Broadway, New York 19, Executive Director.

American Industrial Health Conference, April 11-13, 1961, Biltmore Hotel, Los Angeles, Calif. Clark D. Bridges, 28 E. Jackson Blvd., Chicago, Managing Director.

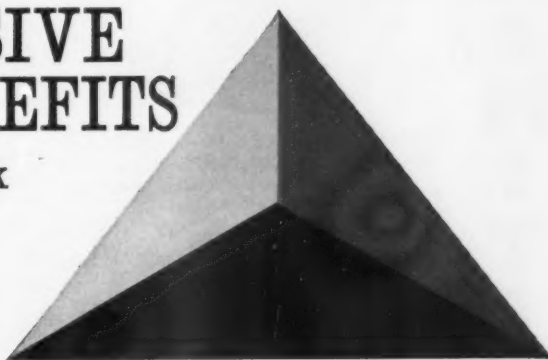
Spring Meeting of American Academy of Pediatrics, April 10-12, 1961, Sheraton-Park Hotel, Washington, D. C. For information write E. H. Christopherson, M.D., 1801 Hinman Ave., Evanston, Ill., Executive Director.

Clinical Reviews, Mayo Clinic and Mayo Foundation, April 10-12, 1961, Rochester, Minnesota; for information contact Clinical Reviews Committee, Mayo Clinic, Rochester, Minnesota.

Ohio State Medical Association, April 10-13, 1961, Netherland-Hilton Hotel, Cincinnati, Ohio. Mr. Charles S. Nelson, 79 E. State St., Columbus 15, Executive Secretary.

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American Academy of General Practice, April 13-20, 1961, Miami Beach, Fla. Mr. Mac F. Cahal, Volker Blvd. at Brookside, Kansas City 12, Mo., Executive Director.

American College of Obstetricians and Gynecologists, April 21-28, 1961, Americana Hotel, Miami Beach, Fla. Mr. Donald F. Richardson, 79 W. Monroe St., Chicago 3, Ill., Executive Secretary.

Thirty-second Annual Meeting of Aerospace Medical Association, April 24-26, 1961, Chicago. William J. Kennard, M.D., c/o Washington National Airport, Washington, D. C., Secretary-Treasurer.

American Association for Thoracic Surgery, April 24-26, 1961, Sheraton Hotel, Philadelphia, Pa. Hiram T. Langston, M.D., 308 Carondelet Bldg., 7730 Carondelet Ave., St. Louis 5, Secretary.

American Pediatric Society, May 2-3, 1961, Hotel Traymore, Atlantic City. Conrad M. Riley, Denver General Hospital, Denver 4, Secretary.

Student American Medical Association, Congress, May 3-7, 1961, Chicago. Mr. Russell F. Staudacher, 430 N. Michigan Ave., Chicago 11, Executive Director.

American Society of Internal Medicine, May 5-7, 1961, Eden Roc Hotel, Miami Beach, Fla. Mr. G. Tod Bates, 350 Post St., San Francisco 8, Executive Director.

American College of Physicians, May 8-12, 1961, Americana Hotel, Miami Beach, Fla. Edward C. Rosenow, Jr., M.D., 4200 Pine St., Philadelphia 4, Executive Director.

American Psychiatric Association, May 8-12, 1961, Morrison Hotel, Chicago. C. H. Hardin Branch, M.D., 156 Westminster Ave., Salt Lake City 15, Utah, Secretary.

Illinois State Medical Society, May 15-18, 1961, Mr. R. Richards, 360 N. Michigan, Chicago 1, Executive Administrator.

American College of Cardiology, Inc., May 16-20, 1961, Biltmore Hotel. Philip Reichert, M.D., 350 Fifth Ave., Empire State Bldg., New York 1, Executive Director.

American Association of Plastic Surgeons (members and guests), May 17-19, 1961, Commodore Hotel, New York City. Thomas D. Cronin, M.D., 6615 Travis St., Houston 25, Texas, Executive Secretary.

American Orthopaedic Association (members and guests), May 22-25, 1961, The Ahwahnee, Yosemite, Calif. Lee Ramsay Straub, M.D., 535 E. 70th St., New York 21, Secretary.

American Urological Association, Inc., May 22-25, 1961, Biltmore Hotel, Los Angeles. Mr. William P. Didusch, 1120 N. Charles St., Baltimore 1, Executive Secretary.

National Tuberculosis Association, May 22-25, 1961, Netherland-Hilton, Cincinnati. Mr. James G. Stone, 1790 Broadway, New York 19, Executive Secretary.

American Otolological Society, Inc., May 26-27, Lake Placid Club, Essex County, N. Y. James A. Moore, M.D., 525 E. 68th St., New York 21, Secretary-Treasurer.

American Gynecological Society, May 29-31, 1961, The Broadmoor, Colorado Springs, Colo. Albert H. Aldridge, M.D., 899 Park Ave., New York 21, President.

American Ophthalmological Society (members only), May, The Homestead, Hot Springs, Va. Joseph A. C. Wadsworth, M.D., 108 E. 68th St., New York 21, Executive Secretary.

## IN MEMORIAM

**SAUL BARNETT, M.D.**, sixty-six, Detroit, ear, nose and throat specialist, died December 4, 1960. Doctor Barnett was a graduate of Detroit Medical College and studied at the University of Vienna. He was a past president of Maimonides Medical Society and a member of Temple Israel and Moslem Shrine.

**HERBERT F. KILBORN, M.D.**, eighty-six, an Ithaca physician, died November 23, 1960.

A native of Ontario, Canada, Doctor Kilborn came to the United States in 1902, having graduated with a Master of Surgery degree from Queens University medical school in 1898. He attended Wayne State University College of Medicine, received his M.D. in this country.

In the more than 50 years he was in active practice, Doctor Kilborn took many postgraduate and short courses in medicine. He was an associate Fellow in Postgraduate Medical Education and held an honorary life membership in the Wayne State University College of Medicine.

Doctor Kilborn was a life member of the Ithaca Masonic Blue Lodge, a member of the Royal Arch Masons and the Knights Templar. He was a charter member and past president of the Ithaca Rotary club.

A recipient of many citations, medals and awards from the

government, the FBI and veterans groups, Doctor Kilborn was awarded the first Ithaca Chamber of Commerce "Community Service Award" in January, 1960.

**JOSEPH O. KOPEL, M.D.**, seventy, Detroit, physician for 48 years, died, December 7, 1960.

A native of Detroit and a graduate of the Detroit College of Medicine in 1912, he was a member of the Jewish Welfare Federation, the Standard Club and Congregation Shaarey Zedek.

**ROBERT L. PHILLIPS, M.D.**, seventy, a retired Flint surgeon, died December 13, 1960.

Doctor Phillips moved to Florida in 1953, after retirement from his Flint practice.

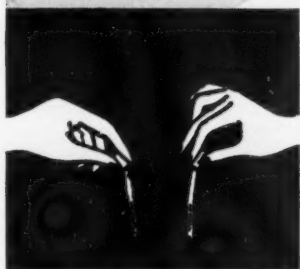
In September, Doctor Phillips was named a life member of the Genesee County and Michigan State Medical Societies, an honor given to physicians who have reached 70 or who have been practicing 50 or more years.

A graduate of Detroit Medical School, Doctor Phillips was licensed to practice medicine in Michigan in 1914. He served an internship at Providence Hospital, Detroit.

In 1929, he completed postgraduate training in obstetrics

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and gynecology at P.D. and Lying-In-Hospital, New York City.

During World War I, Doctor Phillips was a captain in the Army serving with the 351st Ambulance Company, 88th Division.

**WALTER J. WRIGHT, M.D.**, eighty-five, an Ypsilanti physician from 1902 until his retirement in 1948, died November 19, 1960.

Doctor Wright was born in Mason, was graduated from the University of Michigan Medical School in 1898 and later did graduate work at the Johns Hopkins University and at Harvard University.

He was a member of the Methodist Church, a life member of Phoenix Lodge F & AM No. 13, member of the Commandery, Order of Eastern Star, medical affiliations and served as a staff member of the Beyer Memorial Hospital until his retirement and since then had served as an honorary member.

**J. PAUL YEGGE, M.D.**, fifty-five, Muskegon physician, died December 8, 1960.

A native of Boone, Iowa, Doctor Yegge received his M.D. degree from the University of Iowa. He came to Michigan shortly after and practiced for a number of years at Kent City before going to Muskegon to establish a practice three years ago. He was interested in sports and served as team physician for Muskegon Catholic Central High School.

In addition to his professional affiliations, he was a member of Muskegon Elks Lodge, Our Lady of Grace Catholic Church and the Holy Name Society.

#### Michigan Blue Cross Tops \$1 Billion Mark

Michigan Blue Cross has hit and passed one billion dollars in benefit payments for hospital care for Blue Cross members.

Wm. S. McNary, executive vice president, said \$1,000,000,000 in benefits was reached and topped in a check to Sparrow Hospital in Lansing. The check covered services to Blue Cross patients billed by the hospital in November.

Mr. McNary said that payment of more than one billion dollars in benefits for hospital care for Blue Cross members in less than twenty-two years "is an historic and impressive milestone in voluntary prepayment in Michigan."

#### Nursing Scholarship At Wayne University

Applications for six four-year scholarships for Wayne State University's College of Nursing are due on or before March 1 for the fall semester.

Five Helen Newberry Joy Scholarships worth \$1,234 each are offered to residents of Metropolitan Detroit. The College of Nursing Alumni Association Scholarship is worth \$1,150 and is open to any qualified applicant.

Scholarship applications are available at most high schools and through the College of Nursing, Cohn Building, 5557 Cass, Detroit 2.

## COMMUNICATIONS

Michigan State Medical Society

Gentlemen:

At the annual business meeting of the Michigan Probation, Prison and Parole Association held September 29, 1960, the following resolution was unanimously adopted and presented for your consideration and support.

RESOLVED: That the Michigan Medical Association be advised by the Michigan Probation, Prison and Parole Association that the Association has recognized the value of the drug Naline, in the detection of addicts, and that the use of this drug be included as a part of Parole or Probation supervision in cases involving drug addicts.

Respectfully submitted,  
GORDON FULLER, President  
Michigan Probation, Prison and  
Parole Association

Jackson, Michigan  
December 9, 1960

Mr. William J. Burns  
Executive Director  
Michigan State Medical Society

Dear Mr. Burns:

The Dependents' Medical Care Program began its fifth

year of operation on 7 December 1960.

We in the Office for Dependents' Medical Care are extremely proud of the manner in which the Program has been accepted and supported by civilian physicians and hospitals. We are cognizant of the fact that such acceptance would not have been possible but for the highly efficient and conscientious manner in which the various medical societies and fiscal administrators have administered the Program. For this, we are deeply appreciative.

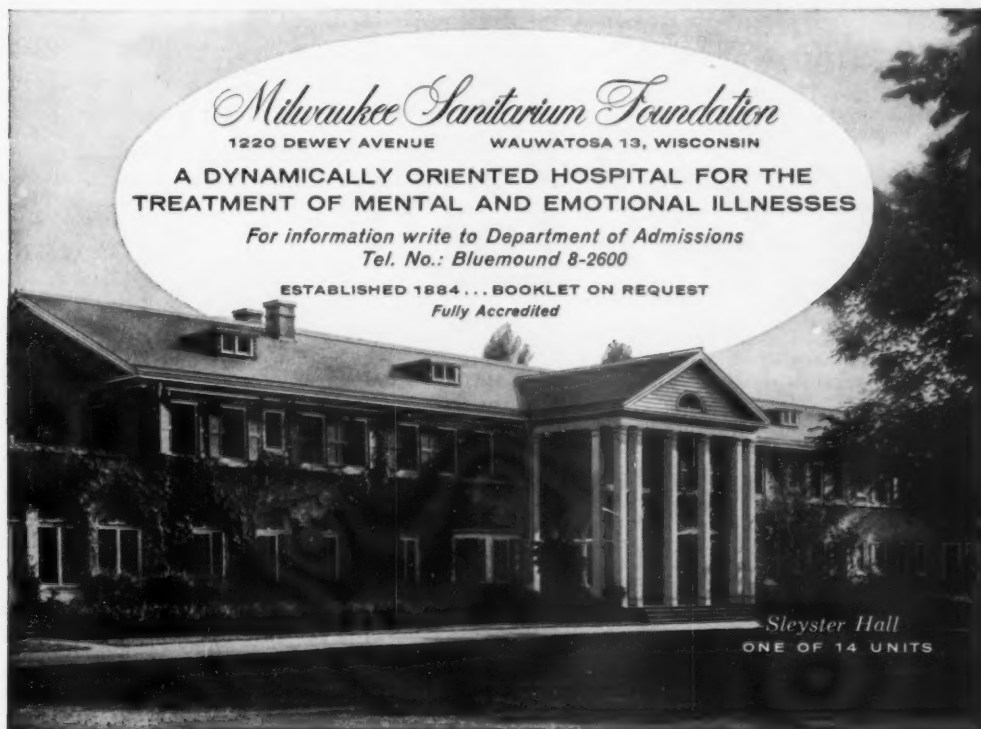
Sincerely,  
FLOYD L. WERGELAND  
Brigadier General, MC  
Executive Director, Office for  
Dependents' Medical Care

### To Give Hickey Lecture

C. Allen Good, M.D., chief of the department of radiology, Mayo Clinic, will deliver the Hickey Memorial Lecture under the combined auspices of the Detroit Roentgen Ray and Radium Society, Wayne County Medical Society and Wayne State University College of Medicine on March 2, at 8 p.m. in the auditorium of the Wayne County Medical Society headquarters.

A subscription dinner will precede the lecture at 7 p.m.

Dr. Good will speak on "Certain Vascular Abnormalities of the Lungs."



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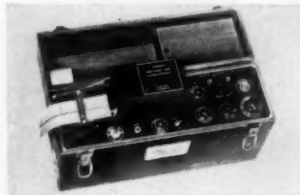
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## The Doctor's Library

Acknowledgments of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review as expedient.

**INFECTIOUS DISEASES OF CHILDREN.** By Saul Krugman, M.D., Professor and Chairman, Department of Pediatrics, New York University School of Medicine, New York, N. Y.; Director, Pediatric Service, Bellevue Hospital Center, New York, N. Y.; Director, Pediatric Service, University Hospital, New York, N. Y., and Robert Ward, M.D., Professor and Head, Department of Pediatrics, University of Southern California School of Medicine, Los Angeles, Calif.; Physician-in-Chief, Children's Hospital, Los Angeles, Calif. Second edition. With 55 Illustrations and 7 Color Plates. St. Louis: The C. V. Mosby Company, 1960. Price, \$13.00.

The book makes the common cold less of an enigma. It resolves colds into an entity with an etiology, course, and treatment. The contagious diseases are carefully described. There are new chapters on acute respiratory infections and enterovirus diseases. Rabies and toxoplasmosis have been added. There is much recent material on herpetic infections, poliomyelitis vaccine, diphtheria, rubella, meningitis and staphylococcus infections. Infectious diseases in children constitute the larger part of the pediatrician's work.

The book is a new and helpful aid to practitioners dealing with infections in children.

R.S.S.

**CONTRIBUTIONS TO OBSTETRICS AND GYNAECOLOGY.** By B. N. Shirodkar, M.D. (Bombay), F.R.C.S. Emeritus Professor of Obstetrics and Gynaecology, Grant Medical College, Bombay. Edinburgh and London: E. & S. Livingstone, Ltd., 1960. Price, \$8.50.

This is an excellent advance in the field of gynecological surgery. The many actual photographs of the various surgical procedures are self explanatory. Definitely, useful contributions in this field are the chapters on prolapse of the uterus, tuboplasty, artificial vagina, and the operative procedure for habitual abortion. Of special interest to all physicians who are doing surgery is the use of mersilene tape and thread. The final chapter is a summary of various papers on gynecology and obstetrics written by the author. One of the most interesting chapters is on cesarean section with use of the Morrison forceps. The diagrams of external version give a very clear illustration of the procedure.

This book is of the greatest importance to all men doing obstetrics and gynecology and to the general surgeon.

J.R.P.

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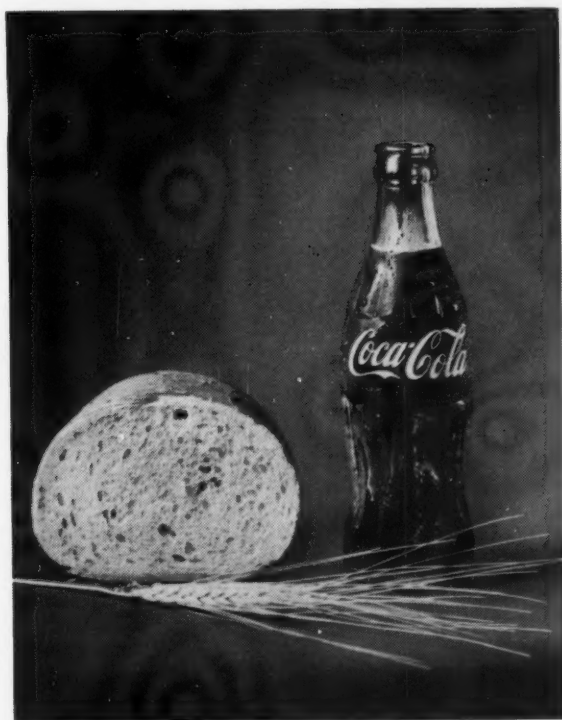
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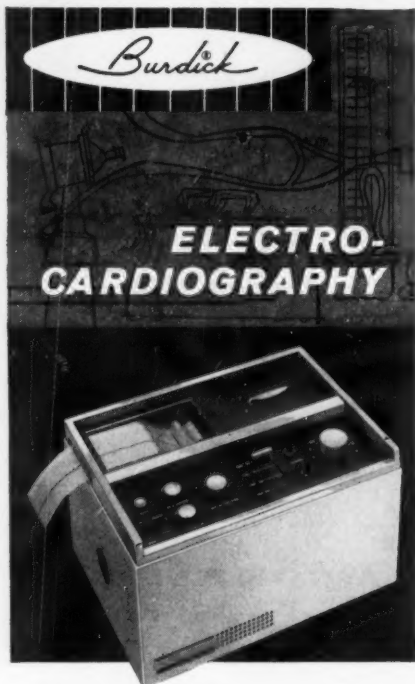


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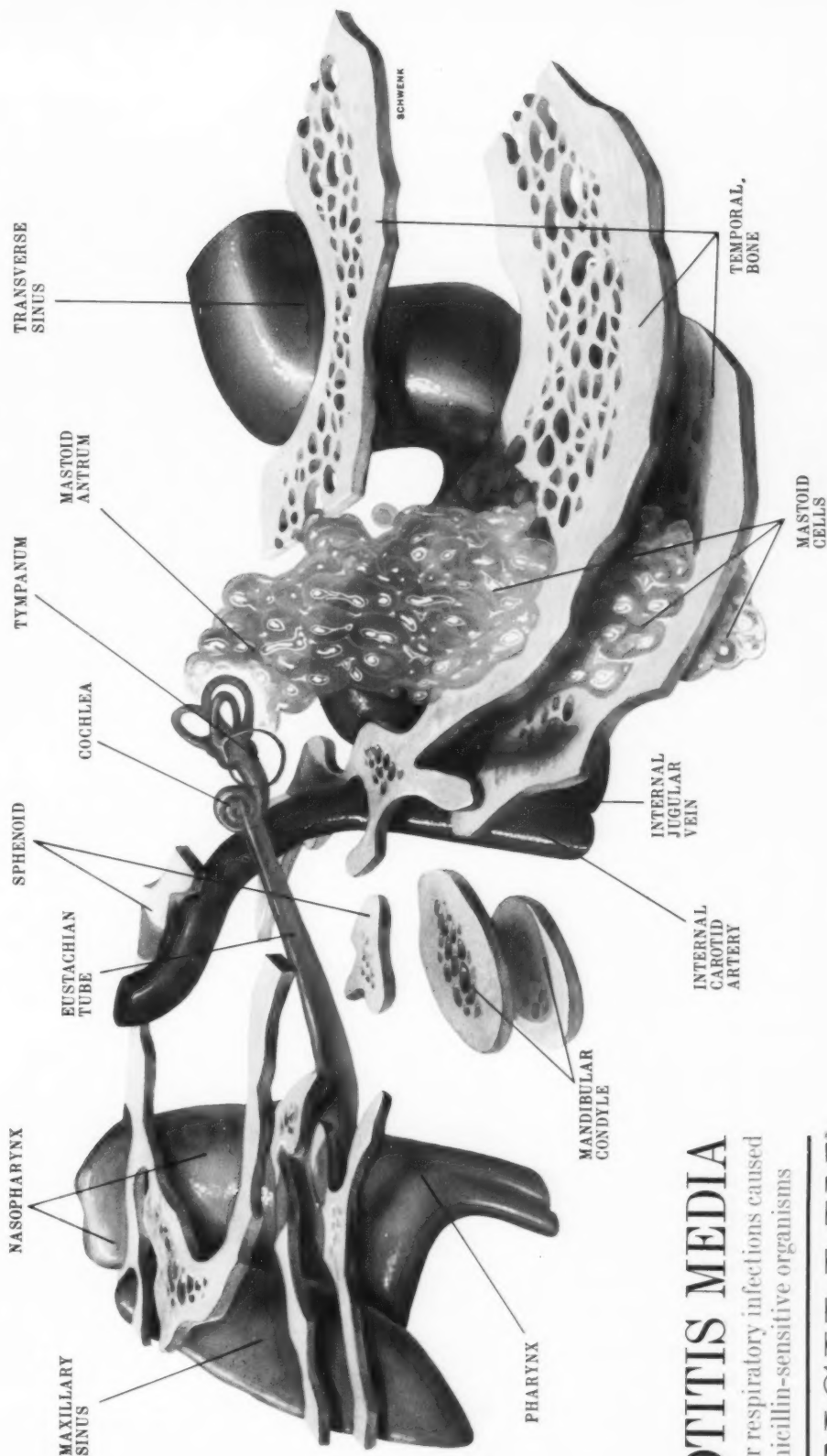
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A dosage form to meet the individual requirements of patients of all ages in home, office, clinic, and hospital: Syncillin Tablets—250 mg. and Syncillin Tablets—125 mg. Syncillin for Oral Solution—60 ml. bottles—when reconstituted, 125 mg. per 5 ml. • Syncillin Pediatric Drops—1.5 Gm. bottles. Calibrated dropper delivers 125 mg.

**Effective in  
vitro antibacterial  
activity against  
penicillin-sensitive  
organisms\***

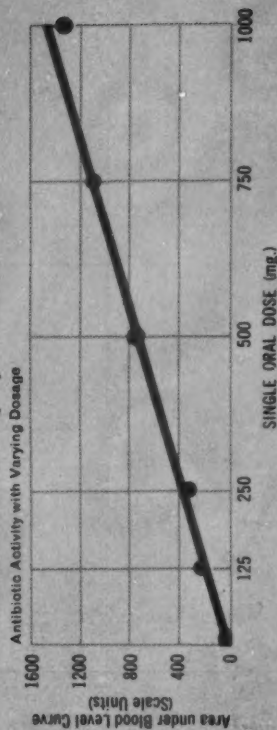
Bacillus anthracis	0.03
Bacillus cereus	20
Bacillus circulans ATCC 9961	0.15
Corynebacterium xerosis	0.03
*Diplococcus pneumoniae	0.06
Escherichia coli ATCC 8739	> 100
Gaffkya tetragena	0.015
Micrococcus flavus	0.015
Salmonella paratyphi A	20
Salmonella typhosa	> 100
Sarcina lutea ATCC 10054	0.007
Shigella sonnei	100
Staphylococcus aureus 209P	0.03
Staphylococcus aureus var. Smith	0.03
Streptococcus agalactiae ATCC 1077	0.03
Streptococcus dysgalactiae ATCC 9926	0.03
Streptococcus faecalis PC1305	0.05
*Streptococcus pyogenes 203	0.06
*Streptococcus pyogenes Dignonet	0.06
Streptococcus pyogenes 2320	0.03
Streptococcus pyogenes 23568	0.06
Vibrio comma	0.06

Serial dilution technique in heart infusion broth \*10% serum added



**BRISTOL LABORATORIES**  
Division of Bristol-Myers Co.  
SYRACUSE, NEW YORK

**Direct control of blood levels:  
serum concentration proportional to size of dose\***



\*As is true with all antibiotics, clinical response does not always correlate exactly with in vitro bacterial sensitivity reports or laboratory blood level findings. However, these are useful guides.

**Dosage:** 125 mg. or 250 mg. 3 times a day, depending on severity of the infection, and on age and weight of the patient. Larger dosage (e.g., 500 mg. t.i.d.) may be used for more severe infections. Although maximum absorption is obtained in the fasting patient, clinically adequate blood levels are almost always obtained when SYNCILLIN is administered with meals. Treatment should be continued until physician is confident infection has been overcome. □ Beta-hemolytic streptococcal infections should be treated for at least 10 days to help prevent the development of rheumatic fever. Even more prolonged therapy may be required for certain staphylococcal infections. □ Complete information on indications and precautions is included in the official circular accompanying each package.



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*A non-profit foundation*

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A facility designed to rehabilitate or to aid the addict in arresting his addiction.

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#### Family Cars

1. Keep brakes adjusted—never slam on brakes on icy roads.
2. Inflate tires moderately—hard tires skid more easily.
3. Keep windshield and rear windows clear of snow and ice.
4. Open garage doors before starting cars—avoid carbon monoxide poisoning.
5. Make sure manifold exhaust pipe and muffler do not leak.

#### Highways

1. Never drive while intoxicated.
2. Observe and obey all highway signs and signals.
3. Use chains on ice and snow covered roads, never on clear pavement.
4. Allow for increased distance to stop on snow or ice covered roads.
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Minimizes bookkeeping



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She's drinking a glass of pure Florida orange juice. And that's important to her physician for several reasons.

*How* your patients obtain their vitamins or any of the other nutrients found in citrus fruits is of great medical interest — considering the fact there are so many wrong ways of doing it, so many substitutes and imitations for the real thing.

Actually, there's no better way for this young lady to obtain her vitamin C than by doing just what she is doing, for there's no better source than oranges and grapefruit ripened in the Florida sunshine. There's no substitute for the result of nature's own mysterious chemistry, flourishing in the warmth of this luxurious peninsula.

An obvious truth, you might say, but not so obvious to the parents of many teen-agers.

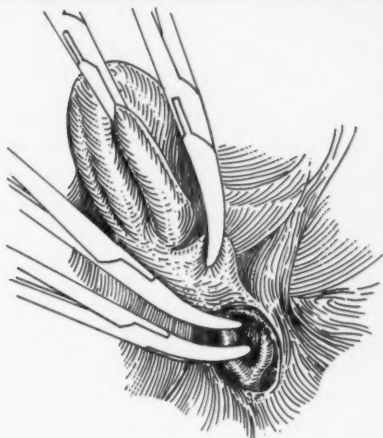
We know that a tall glass of orange juice is just about the best thing they can reach for when they raid the refrigerator. We also know that if you encourage this refreshing and healthful habit, you'll be helping patients to the finest between-meals drink there is.

Nothing has ever matched the quality of Florida citrus — watched over as it is by a State Commission that enforces the world's highest standards for quality in fresh, frozen, canned or cartoned citrus fruits and juices.

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BE REASSURED  
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OF HIS GALLBLADDER  
WILL NOT SERIOUSLY  
IMPAIR HIS DIGESTIVE  
ABILITY?

He may be told that, among animals of similar dietary habits and digestive processes, some have a gallbladder and some do not. Among the herbivores, the cow and sheep have one, the deer and horse do not; among the omnivores, the mouse has one but the rat does not.

Source: Farris, J. M., and Smith, G. K.:  
M. Clin. North America 43:1133 (July) 1959.

when the patient  
needs  
increased bile flow...

## DECHOLIN®

(dehydrocholic acid, AMES)

"Constant loss of bile [from relaxation of sphincter of Oddi following cholecystectomy] reduces the amounts available for lipid absorption after meals, with resulting clinical symptoms apparently relieved by bile acid administration."  
Source: Popper, H., and Schaffner, F.: Liver: Structure and Function, New York, McGraw-Hill 1957, p. 309.

Available: DECHOLIN Tablets: (dehydrocholic acid, AMES) 3 3/4 gr. (250 mg.). Bottles of 100, 500, and 1,000.

and for hydrocholeresis plus  
spasmolysis...

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'Thorazine' is so effective in agitation because it provides an *intense tranquilizing effect*, for control of both emotional and physical hyperactivity; and a *transitory soporific effect*, for added initial control of physical hyperactivity.



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